DIVISION OF EMPLOYMENT SECURITY

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

EMPLOYER REQUEST FOR AN APPEAL OF UNEMPLOYMENT INSURANCE BENEFITS DETERMINATION

Your Name	Job Title	
Name of Business		Date of Determination
Name of Claimant *(Use one Appeal form per claimant)*	Claimant Social Security Number	Mo. Unemployment Tax Account Number

I appeal this determination. Brief statement explaining why: _____

Date	Signature

Mail to:
Division of Employment Security
Appeals Tribunal
P.O. Box 59
Jefferson City, MO 65104

Fax to:
573-751-1321

***IMPORTANT**: If needed, call 573-751-3913 for assistance in the translation and understanding of the information in this document.*

***¡IMPORTANTE!**: Si es necesario, llame al 573-751-3913 para asistencia en la traducción y entendimiento de la información en este documento.*

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