MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

# EMPLOYER REQUEST FOR AN APPEAL OF UNEMPLOYMENT INSURANCE BENEFITS DETERMINATION

| Your Name | | Job Title |
|---|---|---|
| Name of Business | Issue Number | 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