STATE OF ILLINOIS
DEPARTMENT OF EMPLOYMENT SECURITY

APPLICATION FOR RECONSIDERATION OF CLAIMS ADJUDICATOR'S DETERMINATION

Appellant's Name _____ Address _____

Social Security # _____ Date of Claims Adjudicator's Determination _____

REASON FOR REQUEST FOR RECONSIDERATION; I disagree with the claims adjudicator's determination because (Give all your reasons and facts):

_____ Date Signed

_____ Claimant's Signature