

[Date]

[Claimant Name]

[Claimant Address]

[City, State, Zip Code]

Re: Notice of Department Closure and Claim Transfer

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

Dear [Claimant Name],

This letter is to formally notify you that the Workers' Compensation Department at [Company Name] will be closing effective [Closing Date]. As a result, we will no longer be managing your workers' compensation claim internally after this date.

Please be assured that this closure will not impact the status of your benefits or the processing of your claim. Your file is being transferred to our third-party administrator for continued management.

Effective [Transfer Date], your new point of contact will be:

[Name of New Insurance Carrier/TPA]

[Contact Person Name, if applicable]

[Address]

[Phone Number]

[Email Address]

All future medical reports, bills, and inquiries regarding your claim should be directed to the entity listed above. We have transferred all your records to ensure a seamless transition.

Thank you for your cooperation during this transition period.

Sincerely,

[Your Name]

[Your Title]

[Company Name]