

[Company Name]
[Human Resources/Benefits Department]
[Address]
[City, State, Zip Code]

[Date]

[Employee Name]
[Address]
[City, State, Zip Code]

Subject: Notice of Decision Regarding Short-Term Disability Claim

Dear [Employee Name],

We have completed the review of your application for Short-Term Disability (STD) benefits for the period beginning [Start Date of Requested Leave].

At this time, we regret to inform you that your claim for Short-Term Disability benefits has been denied for the following reason(s):

- [Insert Reason: e.g., Medical documentation does not support total disability.]
- [Insert Reason: e.g., Condition falls under a plan exclusion.]
- [Insert Reason: e.g., Documentation was not submitted within the required timeframe.]

Right to Appeal:

If you disagree with this decision, you have the right to file an appeal. You must submit your appeal in writing within [Number] days of receiving this letter. Please include any additional medical evidence or information that supports your claim for benefits.

Impact on Employment:

Because your disability claim was denied, your current absence is not covered under the Short-Term Disability plan. Please contact your manager or the Human Resources department immediately to discuss your return-to-work status or other leave options, such as FMLA or unpaid leave.

If you have any questions regarding this decision or the appeal process, please contact [Contact Name] at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Name of Sender]
[Title]