

[Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Subject: Notification of Exhaustion of Short-Term Disability (STD) Benefits

Dear [Employee Name],

We are writing to inform you that your Short-Term Disability (STD) benefit payments through [Company Name/Insurance Carrier] are scheduled to end on [Date]. According to our records, you will have reached the maximum benefit duration of [Number] weeks/months as of that date.

If you remain unable to return to work due to your medical condition, please review the following options and requirements:

- **Long-Term Disability (LTD):** You may be eligible to transition to Long-Term Disability benefits. Please contact [Insurance Carrier Name] at [Phone Number] to initiate a claim or check the status of an existing application.
- **Return to Work:** If you have been cleared by your physician to return to work, please submit a formal medical release form to the Human Resources department by [Date].
- **Job Protection:** Please be advised that the exhaustion of disability pay is separate from your job-protected leave status under [FMLA/State Law]. Your current leave protection is scheduled to expire on [Date].
- **Reasonable Accommodation:** If you are able to work with specific restrictions, please contact us immediately to discuss potential reasonable accommodations under the Americans with Disabilities Act (ADA).

Failure to return to work or provide updated medical certification regarding your leave status by [Date] may result in the termination of your employment.

Please contact the Human Resources Department at [Phone Number] or [Email Address] if you have any questions regarding your benefits or your return-to-work status.

Sincerely,

[Your Name]

[Your Title]

[Company Name]