[Date]

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

RE: Notice of Exhaustion of Long Term Disability (LTD) Benefits

Dear [Employee Name],

We are writing to formally notify you that your Long Term Disability (LTD) benefits provided through [Insurance Carrier Name] are scheduled to expire on [Date of Benefit Exhaustion].

According to the terms of your policy, you have reached the maximum benefit period allowed for your specific claim. As a result, your final disability payment will be issued on or about [Date of Final Payment].

Please be advised of the following regarding your employment and benefits:

- **Benefit Coverage:** Any supplementary benefits tied to your LTD status, such as life insurance premium waivers or health insurance subsidies, may also terminate on the date mentioned above.
- **Return to Work:** If you are cleared by a physician to return to work in any capacity, please contact the Human Resources Department immediately at [Phone Number] to discuss available positions or reasonable accommodations.
- **Conversion Options:** You may be eligible to convert your group coverage to an individual policy. Please contact [Insurance Carrier Name] at [Carrier Phone Number] within [Number] days to discuss your options.
- **Employment Status:** [Insert company policy regarding employment status following exhaustion of benefits, e.g., Your employment will be administratively terminated effective (Date) unless you return to active duty].

If you believe there has been an error in the calculation of your benefit period, or if you have recently submitted updated medical documentation to the insurer, please notify us and the insurance carrier immediately.

We appreciate your cooperation during this transition. If you have any questions regarding this notice, please contact [Name/Department] at [Email/Phone].

Sincerely,

[Signature]
[Name of Sender]
[Title]
[Company Name]