

[Current Date]

[Employee Name]

[Employee ID]

[Street Address]

[City, State, Zip Code]

Subject: Notice of Short-Term Disability (STD) Overpayment

Dear [Employee Name],

We are writing to inform you that an overpayment has been identified regarding your Short-Term Disability (STD) benefits for the period of [Start Date] to [End Date].

The overpayment occurred due to: [Reason for overpayment, e.g., administrative error, late notification of return to work, or integration with other income].

Overpayment Details:

- Total Amount Paid: \$[Amount]
- Correct Benefit Amount: \$[Amount]
- **Total Overpayment Balance: \$[Amount]**

We request that this amount be repaid to the company. Please select one of the following repayment options:

1. **Lump Sum Payment:** A check or money order for the full amount payable to [Company Name] by [Date].
2. **Payroll Deduction:** A deduction of \$[Amount] per pay period for [Number] pay periods, starting on [Date].
3. **Installment Plan:** Please contact the Benefits Department to discuss an alternative repayment schedule.

Please sign and return this letter by [Date] to confirm your preferred repayment method. If we do not hear from you by this date, we will proceed with [Default Action, e.g., automatic payroll deduction].

If you believe this calculation is in error or if you have any questions, please contact the Benefits Department at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]

[Sender Title]

[Company Name]

Employee Acknowledgement:

I acknowledge the overpayment and agree to the following repayment method: [Selected Option]

Signature: _____ Date: _____