Date: [Insert Date]

To: [Insurance Carrier Name]
Attn: Claims Department
Address: [Carrier Address]
City, State, Zip: [City, State, Zip]

RE: Workers' Compensation Coordination of Benefits

Claimant Name: [Employee Name]
Date of Injury: [Date of Incident]
Claim Number: [Claim Number]
Employer: [Company Name]

To Whom It May Concern,

This letter is to formally coordinate the benefits regarding the above-referenced workers' compensation claim. We are providing notice of additional coverage information to ensure the proper sequencing of payments and to prevent the duplication of benefits.

Please find the following information regarding the claimant's other benefit sources:

- **Group Health Insurance:** [Provider Name / Policy Number]
- **Short/Long Term Disability:** [Provider Name / Policy Number]
- **Social Security Disability:** [Status / Claim Number if applicable]

We request that you review the current payment status of this claim. If any medical expenses or indemnity payments have been overpaid or if a lien needs to be established for reimbursement of benefits paid by other sources, please notify the undersigned immediately.

Please provide an updated Statement of Benefits Paid and any relevant medical-legal documentation to our office within [Number] business days.

Thank you for your prompt attention to this coordination of benefits.

Sincerely,

[Your Name]
[Your Title]
[Your Company/Organization]
[Phone Number]
[Email Address]