

[Sender Name]
[Sender Title/Company]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Recipient Name/Insurance Adjuster]
[Insurance Carrier Name]
[Address Line 1]
[City, State, Zip Code]

RE: Notice of Permanent Total Disability Status

Claimant: [Employee Name]

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

To Whom It May Concern,

This letter serves as formal notification regarding the disability status of [Employee Name]. Based on the medical evaluation and Final Medical Report issued by [Physician Name] on [Date], it has been determined that the claimant has reached Maximum Medical Improvement (MMI).

The clinical findings indicate that the claimant's injuries sustained on [Date of Injury] have resulted in permanent functional limitations that preclude them from engaging in any gainful employment. Consequently, the claimant is being classified as having a **Permanent Total Disability (PTD)**.

As a result of this status, we request the following:

- Commencement of permanent total disability benefit payments as mandated by state workers' compensation laws.
- A formal summary of the calculated life expectancy benefits and cost-of-living adjustments, if applicable.
- Confirmation of continued coverage for reasonable and necessary medical treatment related to the workplace injury.

Attached please find the supporting medical documentation and the permanent impairment rating report. Please update your records to reflect this change in status and confirm receipt of this notification in writing.

Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Signature]

[Printed Name]