

DATE: [Insert Date]

TO: [Employee Name]

ADDRESS: [Insert Employee Address]

**SUBJECT: FINAL WARNING AND NOTICE OF WORKERS' COMPENSATION
BENEFIT CANCELLATION**

Dear [Employee Name],

This letter serves as a formal final warning regarding your employment status and the official notification of the cancellation of your Workers' Compensation benefits, effective [Insert Date].

Reason for Cancellation:

Your benefits are being terminated based on the following reason(s):

- [Insert Reason, e.g., Failure to attend mandatory medical evaluations]
- [Insert Reason, e.g., Release to full duty by attending physician on Date]
- [Insert Reason, e.g., Failure to return to work under offered light-duty restrictions]
- [Insert Reason, e.g., Non-compliance with the rehabilitation plan]

Employment Status:

Please be advised that this is your final warning. Your failure to [Insert Required Action, e.g., report to work/provide updated medical documentation] by [Insert Deadline Date] will result in the immediate termination of your employment with [Company Name].

Right to Appeal:

If you disagree with the decision to cancel your Workers' Compensation benefits, you have the right to contest this action. You may file a claim or appeal with the [Insert State/Local Workers' Compensation Board Name] within [Insert Number] days of receiving this notice.

Please contact [Insert Name/Department] at [Insert Phone Number] immediately if you have any questions regarding this notice or your return-to-work requirements.

Sincerely,

[Your Name]

[Your Title]

[Company Name]

CC: [Insurance Carrier Name]

[Personnel File]