[Company Name]
[HR Department]
[Company Address]
[City, State, Zip Code]

[Date]

[Employee Name]
[Employee ID]
[Employee Address]

Subject: Notice of Short-Term Disability (STD) Benefit Approval and Payment Breakdown

Dear [Employee Name],

We are writing to confirm that your claim for Short-Term Disability (STD) benefits has been approved. Your benefits are scheduled to begin following the completion of your mandatory elimination period.

Below is the breakdown of your disability benefit payments:

- **Disability Start Date:** [Date]
- **Elimination Period:** [Number] Days (Ends on [Date])
- **Benefit Effective Date:** [Date]
- **Benefit Percentage:** [Percentage]% of your gross weekly earnings
- **Gross Weekly Benefit Amount:** $[Amount]
- **Tax Withholdings (Federal/State):** $[Amount]
- **Other Deductions (Health Premiums, etc.):** $[Amount]
- **Net Weekly Benefit Amount:** $[Amount]

Payment Schedule:
Your benefits will be issued on a [Weekly/Bi-Weekly] basis. The first payment is expected to be issued on [Date].

Benefit Duration:
Based on your current medical documentation, your benefits are approved through [Date]. If you are unable to return to work by this date, updated medical documentation must be submitted by [Date] to avoid an interruption in payments. The maximum duration for benefits under this policy is [Number] weeks.

Return to Work Requirements:
Before returning to active duty, you are required to provide a "Fitness for Duty" certification from your healthcare provider. Please notify [Contact Name/Department] at least [Number] days prior to your anticipated return date.

If you have any questions regarding this breakdown or your coverage, please contact the Human Resources Department at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Sender Name]
[Sender Title]