[Your Name/Law Firm Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Notice of Representation and Authorization
Claimant Name: [Client Full Name]
Claim Number: [Claim Number]
Policy/Group Number: [Policy Number]
Date of Birth: [Client Date of Birth]

To Whom It May Concern,

Please be advised that this office has been retained to represent [Client Name] in connection with their claim for Long Term Disability (LTD) benefits.

Effective immediately, please direct all future correspondence, inquiries, and documentation regarding this claim to my attention at the address listed above. Do not contact my client directly concerning this matter.

Enclosed, please find a signed Authorization for Release of Information. Pursuant to this authorization, I am requesting a complete copy of my client's administrative claim file. This request includes, but is not limited to:

- The complete insurance policy and Summary Plan Description (SPD).
- All medical records and clinical notes.
- All internal logs, memos, and correspondence related to the claim.
- Vocational reports and surveillance materials, if any.
- A detailed statement of benefits paid or denied to date.

Please provide these documents within [Number, e.g., 30] days of receipt of this letter. If there are any forms required by your office to facilitate this transition of communication, please forward them to me immediately.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosure: Signed HIPAA/Release Authorization