

# Periodic Disability Review Notification

Date:

To:

Address:

Dear ,

This letter is to notify you that a periodic review of your disability status is required. The purpose of this review is to ensure that you continue to meet the eligibility criteria for disability benefits.

Please complete the attached forms and provide any requested medical documentation within 30 days from the date of this notice. Failure to respond may result in the suspension or termination of your benefits.

If you have any questions regarding this review or the required documentation, please contact our office at .

Sincerely,

Disability Benefits Review Officer