Over 7 Approved - F

(date) (post-date the letter 7-10 working days)

worker's name
street address
city, state zip (no abbreviations in the address)

RE: IW name
Claim No. [claim number]

Dear [worker's name]:

Thank you for your letter requesting time-loss compensation benefits [permanent disability benefits] related to your earlier workplace injury or illness.

After reviewing your claim file, I have decided to grant you these benefits, effective [date]. A legal notice with more information will be mailed separately to you.

When a claim has been closed for more than seven years (10 years for eye injuries), benefits may be resumed only in exceptional circumstances such as yours, and must be my decision.

If you have any further questions or concerns, please contact Claim Manager [name] at [area code, telephone number].

Sincerely,

Paul Trause
Director

cc: [attending physician's name]
[employer's name]
[claim manager's name and title]