

[Date]

[Recipient Name]

[Recipient Address]

[City, State, Zip Code]

Subject: Verification of Disability Income Benefits

To Whom It May Concern,

This letter is to formally verify the disability income benefits currently being paid to [Employee Name] under the employer-sponsored disability plan provided by [Company Name].

Employee Information:

- Employee Name: [Employee Name]
- Social Security Number (Last 4 digits): [XXX-XX-0000]
- Date of Disability Onset: [Date]

Benefit Details:

- Benefit Type: [Short-Term Disability / Long-Term Disability]
- Gross Benefit Amount: \$[0,000.00]
- Payment Frequency: [Weekly / Bi-Weekly / Monthly]
- Benefit Start Date: [Date]
- Estimated Benefit End Date: [Date or "Ongoing"]

Please note that these benefits are [Taxable / Non-Taxable] for federal income tax purposes. This income is guaranteed as long as the recipient continues to meet the eligibility requirements defined by the insurance policy.

If you require any further documentation or have additional questions, please contact the [Human Resources / Benefits] department at [Phone Number] or [Email Address].

Sincerely,

[Signature]

[Name of Authorized Representative]

[Title]

[Company Name]