[Date]

[Recipient Name]
[Recipient Title/Department]
[Organization Name]
[Street Address]
[City, State, Zip Code]

Subject: Verification of Long Term Disability Income for [Claimant Full Name]

To Whom It May Concern,

This letter is to formally verify that [Claimant Full Name] is currently receiving Long Term Disability (LTD) benefits provided by [Insurance Company/Provider Name].

The following details pertain to the benefit coverage:

- **Claim Number:** [Claim Number]
- **Benefit Start Date:** [Date Benefits Began]
- **Gross Monthly Benefit Amount:** $[Amount]
- **Net Monthly Benefit Amount:** $[Amount] (after taxes and offsets, if applicable)
- **Frequency of Payment:** [Monthly/Bi-Weekly]
- **Current Status:** [Active/Approved]
- **Next Review Date:** [Date or "Not Applicable"]

These benefits are scheduled to continue as long as the claimant remains disabled under the terms of the policy or until [End Date/Age of Retirement].

If you require additional information or further documentation, please contact our office directly at [Phone Number] or via email at [Email Address].

Sincerely,

[Signature]
[Name of Representative]
[Title]
[Insurance Company/Agency Name]