

**[Insurance Company or Employer Name]**

[Street Address]

[City, State, Zip Code]

[Phone Number]

**[Date]**

**[Mortgage Company Name]**

[Mortgage Company Address]

[City, State, Zip Code]

**RE: Verification of Disability Income Continuation**

**Borrower Name:** [Borrower Full Name]

**Policy/Claim Number:** [Number]

To Whom It May Concern,

This letter is to confirm that **[Borrower Name]** is currently receiving disability benefit payments from **[Name of Entity Providing Payments]**. These benefits are being paid due to a **[Short-Term / Long-Term]** disability claim.

The current benefit details are as follows:

- **Benefit Amount:** \$[Amount] per [Month/Week]
- **Frequency of Payment:** [Monthly/Bi-Weekly/Weekly]
- **Start Date of Benefits:** [Date]
- **Tax Status:** [Taxable / Non-Taxable]

Based on the current medical documentation and the terms of the governing policy, these benefits are scheduled to continue until **[Termination Date]**, or for at least the next three years, provided the recipient continues to meet the eligibility requirements defined in the policy.

If you require any further information or documentation regarding this claim, please contact our office directly at [Phone Number].

Sincerely,

[Authorized Signature]

[Printed Name]

[Title/Position]

[Organization Name]