

[Current Date]

[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Verification of Disability Benefits

Claimant Name: [Full Name of Insured]
Policy Number: [Policy Number]
Claim Number: [Claim Number]
Last 4 Digits of SSN: [#####]

To Whom It May Concern,

This letter is a formal request for written verification of the disability benefits currently being paid to the individual named above. This information is required for [state reason: e.g., mortgage application, social service eligibility, legal proceedings].

Please provide a statement including the following details:

- The date disability benefits commenced.
- The frequency of payments (e.g., weekly, monthly).
- The gross benefit amount per payment period.
- The net benefit amount after any deductions (taxes, offsets, etc.).
- The current status of the claim (e.g., active, pending review).
- The anticipated end date of benefits, if applicable.

Please send this verification letter to the following address:

[Your Name or Recipient Name]
[Mailing Address]
[City, State, Zip Code]
[Email Address/Fax Number]

If you require a signed authorization form or further information to release these details, please contact me immediately at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name]