

[Date]

[Recipient Name]

[Recipient Title/Organization]

[Recipient Address]

[City, State, Zip Code]

**Subject: Verification of Short Term Disability Benefits**

To Whom It May Concern,

This letter is to verify that [Employee Full Name] is currently receiving Short Term Disability (STD) benefits through [Company Name/Insurance Carrier].

The details of the benefit payments are as follows:

- **Benefit Start Date:** [Start Date]
- **Expected End Date:** [End Date/Ongoing]
- **Gross Benefit Amount:** \$[Amount]
- **Payment Frequency:** [Weekly/Bi-weekly/Monthly]

Please note that these benefits are temporary and are subject to periodic medical review. Taxes [are/are not] being withheld from these payments.

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

Sincerely,

[Signature]

[Name of Authorized Representative]

[Title]

[Organization Name]