Disability Insurance Coverage Confirmation

Date: [Insert Date]

To Whom It May Concern,

This letter serves to confirm that [Insured's Name], Policy Number: [Policy Number], is currently covered under our disability insurance plan. This coverage is applicable for any claims related to disability as defined in the policy guidelines.

The policy provides benefits for the period starting from [Start Date] up to [End Date] or until the insured is able to return to work, whichever comes first.

Please find the necessary details below:

- **Insured's Name:** [Insured's Name]
- **Policy Number:** [Policy Number]
- **Coverage Start Date:** [Start Date]
- **Coverage End Date:** [End Date]

Should you require any additional information or documentation regarding this coverage, please do not hesitate to contact us at [Contact Information].

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Insurance Company Name]

[Insurance Company Contact Information]