Disability Insurance Coverage Confirmation

Date: [Insert Date]

To Whom It May Concern,

We are pleased to confirm that [Dependent's Name], under policy number [Policy Number], is covered under our disability insurance plan. This coverage includes assistance for any disabilities that may affect their ability to work.

Coverage Details:

- Policy Holder: [Policy Holder's Name]
- Dependent's Name: [Dependent's Name]
- Coverage Start Date: [Start Date]
- Coverage End Date: [End Date]
- Monthly Benefit Amount: [Benefit Amount]

If you require any further information, please do not hesitate to contact our office at [Contact Information].

Sincerely,

[Your Name]
[Your Title]
[Company Name]
[Company Contact Information]