# Disability Insurance Coverage Confirmation

Date: [Insert Date]

Employee Name: [Insert Employee Name]

Employee ID: [Insert Employee ID]

Department: [Insert Department]

Dear [Employee Name],

This letter is to confirm that your disability insurance coverage is active during your leave of absence. Your policy number is [Insert Policy Number]. Your coverage will remain in effect as per the terms outlined in your employment agreement and our disability insurance policy.

Please feel free to reach out to the HR department if you have any questions or need further assistance regarding your coverage.

Wishing you a smooth recovery.

Sincerely,

[Insert Your Name]

[Insert Your Job Title]

[Insert Company Name]

[Insert Company Contact Information]