Disability Insurance Coverage Confirmation

Date: [Insert Date]

Policyholder Name: [Insert Policyholder Name]

Address: [Insert Address]

City, State, Zip: [Insert City, State, Zip]

Dear [Insert Policyholder Name],

We are pleased to confirm that your disability insurance policy is active and in good standing. Below are the details of your coverage:

- Policy Number: [Insert Policy Number]
- Coverage Amount: [Insert Coverage Amount]
- Effective Date: [Insert Effective Date]
- Monthly Premium: [Insert Monthly Premium]

This policy provides you with financial protection in the event of a disability that prevents you from working. Please keep this confirmation for your records.

If you have any questions or need further assistance, do not hesitate to contact us at [Insert Phone Number] or [Insert Email Address].

Sincerely,

[Your Company Name]

[Your Company Address]

[Your Company Phone Number]

[Your Company Email Address]