Verification of Family Coverage Extension

Date: [Insert Date]

To Whom It May Concern,

This letter is to verify that [Employee Name], holding the position of [Employee Position] at [Company Name], is eligible for an extension of family coverage under [Insurance Provider Name] as part of the company's health benefits plan.

Details of the Coverage Extension:

- Employee Name: [Employee Name]
- Policy Number: [Policy Number]
- Coverage Type: Family Coverage
- Effective Date: [Effective Date]
- Dependent Names: [Dependent Names]

If you require further information or verification, please do not hesitate to contact us at [Contact Information].

Sincerely,

[Your Name]

[Your Position]

[Company Name]

[Company Address]

[Company Phone Number]