

# Medical Insurance Confirmation

Date: [Insert Date]

To Whom It May Concern,

This letter is to confirm that [Insured's Name] is covered under our temporary medical insurance plan with policy number [Policy Number]. This coverage is valid from [Start Date] to [End Date].

Details of Coverage:

- Type of Coverage: [Type of Coverage]
- Provider Network: [Network Name]
- Coverage Limits: [Coverage Limits]
- Emergency Contact: [Emergency Contact Information]

If you have any questions or require further information, please do not hesitate to contact us at [Insurance Company Contact Information].

Thank you.

Sincerely,

[Your Name]

[Your Title]

[Insurance Company Name]

[Company Address]

[Company Phone Number]