Company Name
Company Address
City, State ZIP Code
Phone: (___) ___-____

[Date]

To Whom It May Concern,

Re: Employer Verification Letter for Disability Insurance Reinstatement

This letter serves to verify the employment of [Employee Name], who is currently employed with [Company Name] as a [Employee Job Title].

[Employee Name] has been employed with our organization since [Employment Start Date] and is currently in [full-time/part-time] status.

We understand that [Employee Name] is seeking reinstatement of their disability insurance benefits. Please be advised that [he/she/they] remain[s] an active employee and is eligible for continued employment upon approval of disability insurance benefits.

Should you require any additional information, please contact me at the phone number or email address provided below.

Sincerely,

[Employer Representative Name]
[Title]
[Company Name]
[Email Address]
[Phone Number]