[Company Name]
[HR Department Address]
[City, State, Zip Code]
[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Subject: Continuation of Benefits During Short-Term Disability Leave

Dear [Employee Name],

This letter is to confirm the status of your employee benefits during your approved Short-Term Disability (STD) leave, effective [Start Date].

While you are on leave, your enrollment in the following benefit plans will continue:

- [Benefit 1: e.g., Medical Insurance]
- [Benefit 2: e.g., Dental/Vision Insurance]
- [Benefit 3: e.g., Life Insurance]

Premium Payments:
To maintain your coverage, you are responsible for paying your portion of the monthly premiums. Since you are not receiving a standard paycheck from which deductions can be made, please follow the instructions below:

- Your monthly contribution amount: $[Amount]
- Payment Due Date: [Date of each month]
- Payment Method: [Instructions, e.g., Check payable to Company Name]

Impact on Other Benefits:
[Insert details regarding 401k contributions, PTO accrual, or other specific company policies during leave].

Please note that failure to submit your premium payments by the due date may result in a loss of coverage. If you have questions regarding your benefits or the payment process, please contact the Human Resources Department at [Phone Number] or [Email Address].

We wish you a steady recovery and look forward to your return.

Sincerely,

[Name]
[Title]
[Company Name]