

[Company Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

[Date]

[Claimant Name]
[Address Line 1]
[City, State, Zip Code]

RE: Notice of Disability Benefit Approval

Claim Number: [Claim Number]

Policy Number: [Policy Number]

Dear [Claimant Name],

We are pleased to inform you that your claim for disability income benefits has been approved. Based on the medical documentation provided, it has been determined that you meet the definition of disability under the terms of your policy effective [Disability Start Date].

Payment Details:

- **Monthly Benefit Amount:** \$[Amount]
- **Benefit Start Date:** [Date]
- **Payment Frequency:** [Monthly/Bi-Weekly]
- **First Payment Issue Date:** [Date]

Your initial payment in the amount of \$[Amount] is being issued via [Check/Direct Deposit]. This payment covers the period from [Start Date] to [End Date].

Ongoing Requirements:

To continue receiving benefits, you may be required to provide periodic medical updates from your attending physician. We will notify you in advance when updated documentation is needed. Please inform us immediately if there is any change in your medical status, if you return to work in any capacity, or if you begin receiving Social Security Disability benefits.

If you have any questions regarding your benefits or this approval, please contact your Claims Representative at [Phone Number] or via email at [Email Address].

Sincerely,

[Sender Name]
[Title]
[Company Name]