[Company Letterhead or Return Address]

[Date]

[Insurance Provider Name]
[Insurance Provider Address]
[City, State, Zip Code]

RE: Employment and Dependent Coverage Verification

To Whom It May Concern,

This letter is to formally verify the employment and insurance status of our employee, [Employee Full Name].

Employee Information:
Employee Name: [Employee Full Name]
Social Security Number (Last 4 digits): [XXX-XX-0000]
Date of Hire: [Date]

Dependent Information:
We confirm that the following dependent(s) are currently covered under the employee's group health insurance plan provided by [Company Name]:

- [Dependent Name] - [Relationship to Employee]
- [Dependent Name] - [Relationship to Employee]

Coverage Details:
Plan Name: [Plan Name/Type]
Group Policy Number: [Policy Number]
Member ID: [Employee Member ID]
Coverage Effective Date: [Date]

The coverage for the above-named dependent(s) is currently active and in good standing. If you require any additional information, please contact the Human Resources Department at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Printed Name]
[Title]
[Company Name]