[Current Date]

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

RE: Employment Verification for Insurance Continuity

To Whom It May Concern,

This letter is to formally verify the employment status of [Employee Name] for the purpose of maintaining continuous insurance coverage. [Employee Name] is currently employed with [Company Name] as a [Job Title].

Please be advised that [Employee Name] has been granted an approved leave of absence starting from [Start Date of Leave]. The expected return-to-work date is [Expected Return Date].

During this period, [Employee Name] remains an active employee of [Company Name]. It is our intent to continue their participation in the group [Medical/Dental/Vision] insurance plan(s) under Policy Number: [Policy Number].

Premium payments during this leave will be handled as follows: [Insert payment arrangement, e.g., "via direct billing" or "continued payroll deduction"].

If you require any further documentation or information regarding this leave of absence, please contact the Human Resources department at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Name of HR Representative]
[Title]
[Company Name]