[Company Letterhead]

[Date]

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

RE: Employment and Salary Verification for [Employee Full Name]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This letter is to formally verify the employment and compensation details for [Employee Full Name] for the purpose of their disability insurance claim.

Employment Status:

- **Current Status:** [Active / On Leave / Terminated]
- **Job Title:** [Job Title]
- **Hire Date:** [MM/DD/YYYY]
- **Last Day Worked:** [MM/DD/YYYY, if applicable]
- **Employment Type:** [Full-time / Part-time]

Compensation Details:

- **Base Annual Salary:** $[Amount]
- **Hourly Rate:** $[Amount, if applicable]
- **Average Weekly Hours:** [Number of Hours]
- **Bonus/Commissions (Last 12 Months):** $[Amount]
- **Date of Last Pay Increase:** [MM/DD/YYYY]

Benefit Information:

[Employee Full Name] [is / is not] currently enrolled in a company-sponsored short-term or long-term disability plan. Their premium contributions are paid on a [Pre-tax / Post-tax] basis.

If you require any further documentation or have additional questions, please contact the Human Resources department at [Phone Number] or via email at [Email Address].

Sincerely,

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