Sample Salary Continuation Plan Agreement

Date:

Partner or Employee
Address
City, State, ZIP

Dear ___________:

This letter will serve as notification of the disability Salary Continuation Plan in effect for *<Business Name>*. The Plan's effective date is __________________.

Under this Plan *<Business Name>* will continue your full salary for ____ weeks in the event a sickness or injury causes you to become disabled and unable to perform the duties of your job. Documentation of your disability by a medical practitioner may be required.

Disabilities lasting longer than ____ weeks will not be compensated by the continuance of salary. After ____ weeks of disability, a disability insurance benefit will be paid to you under the terms of the disability insurance policy provided by *<XYZ Insurance Company>*. These benefits are defined in the policy and subject to any limitations or exclusions in the policy. To the extent the insured portion of this plan is an employee benefit plan under ERISA, your policy or certificate of coverage will serve as a summary plan description.

Premiums for the disability insurance policy will be paid by *<Business Name>* until further notice. *<Business Name>* reserves the right to cancel or change this agreement and the insurance policy.