

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

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

Subject: Appeal for Disability Insurance Claim Denial - [Your Policy/Claim Number]

Dear [Claims Adjuster's Name],

I am writing to formally appeal the denial of my disability insurance claim (Claim Number: [Your Claim Number]), dated [Date of Denial]. I was notified of this decision on [Date You Received Denial], and I believe the denial was made in error.

[Briefly explain the reason for the denial and state your disagreement. Include any relevant details from your claim that support your case.]

Since the time of my initial claim, I have [mention any additional medical treatments, tests, or documentation that supports your claim].

Enclosed you will find the following documents to support my appeal:

1. [List Document 1: e.g., additional medical records, doctor's notes]
2. [List Document 2: e.g., test results, statements from healthcare professionals]
3. [List Document 3: e.g., any other relevant documentation]

I respectfully request that you reconsider your decision based on this new information and approve my claim for disability benefits. I am willing to provide any further information or documentation needed to help facilitate this appeal.

Thank you for your attention to this matter. I hope for a prompt response, and I look forward to resolving this issue amicably.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

[Your Policy Number]

Enclosures: [List the enclosed documents]