Application for Retroactive Disability Insurance Coverage

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to formally request retroactive coverage for my disability insurance policy, which I believe should have been effective as of [Insert Date]. Due to [briefly explain reason for delay, e.g., "an unexpected medical condition"], I was unable to file my claim within the standard timeframe.

As of [Insert Date], I have been diagnosed with [specific condition], which has significantly impacted my ability to work. I have attached the relevant medical documentation and other supporting materials to confirm my condition and its impact on my daily activities.

I kindly ask you to consider my circumstances and grant retroactive insurance coverage from the date my disability began. Thank you for your attention to this matter, and I look forward to your prompt response.

Sincerely,

[Your Name]

[Your Policy Number]