Disability Insurance Benefit Claim Appeal

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 [Claims Adjuster's Name],

I am writing to formally appeal the decision regarding my disability insurance claim (Claim Number: [Insert Claim Number]), which was denied on [Insert Date of Denial]. I believe this decision was made in error, and I would like to provide additional information to support my case.

My claim was denied due to [Briefly State Reason for Denial]. However, I would like to contest this decision based on the following grounds:

- [Grounds for Appeal #1 - detail specific evidence or information]
- [Grounds for Appeal #2 - detail specific evidence or information]
- [Grounds for Appeal #3 - detail specific evidence or information]

Enclosed are the relevant documents that support my appeal, including [list of enclosed documents, such as medical records, letters from healthcare providers, etc.].

I respectfully request a thorough review of my appeal and a reconsideration of my claim for disability benefits. Please do not hesitate to contact me at [Your Phone Number] or [Your Email Address] if you require any additional information.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)] [Your Printed Name]