

Appeal for Motor Vehicle Accident Benefits

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[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 motor vehicle accident benefits claim, referenced by claim number [Insert Claim Number]. Following my accident on [Insert Date of Accident], I submitted a claim for [briefly describe the benefits being claimed].

On [Insert Date of Denial], I received a letter denying my claim based on [briefly state reason for denial]. I believe this decision was made in error for the following reasons:

1. [Reason 1]
2. [Reason 2]
3. [Reason 3]

To support my appeal, I have attached the following documents:

- [Document 1]
- [Document 2]
- [Document 3]

I kindly request a thorough review of my case and a reconsideration of the benefits entitled to me. Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you need 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]