Letter of Appeal

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Appeal for Denied Disability Insurance Claim - [Claim Number]

Dear [Claims Adjuster's Name],

I am writing to formally appeal the denial of my disability insurance claim (Claim Number: [Claim Number]), which was denied on [Date of Denial] due to [specific reason for denial]. I believe that this decision was made in error, and I wish to provide additional information for your review.

[Briefly explain your condition and how it impacts your ability to work. Include any new medical documentation or evidence that supports your claim.]

Enclosed with this letter are copies of [list any documents you are including, such as medical records, additional statements, etc.] that further substantiate my claim. I kindly ask you to review this information and reconsider your decision.

I appreciate your attention to this matter and look forward to your prompt response. Please feel free to contact me at [your phone number] or [your email address] should you need any further information.

Thank you for your time.

Sincerely,

[Your Name]