# Appeal for Denial of Disability Benefits Claim

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Claims Adjuster's Name],

I am writing to formally appeal the denial of my disability benefits claim, reference number [Insert Claim Number], which was denied on [Insert Date of Denial]. I appreciate the time and effort your team has put into reviewing my claim, but I believe that the decision made does not accurately reflect my medical condition and its impact on my ability to work.

On [Insert Date of Denial], I received the letter detailing the reasons for the denial. According to the letter, my claim was denied due to [Insert Reason for Denial]. I would like to provide additional evidence and clarify my situation.

Attached, please find [List any attached documents such as medical reports, letters from doctors, etc.]. These documents provide comprehensive details about my condition and my inability to perform my job duties. I trust that this information will assist in a thorough re-evaluation of my claim.

I kindly ask that you review my appeal and the attached documents. I hope for a positive outcome and am willing to provide any further information needed to support my case. Thank you for your understanding and consideration.

Sincerely,

[Your Name]