Date:
Your Name
Your Address
City, State ZIP Code

Insurance Company Name
Attn: Claims Department
Insurance Company Address
City, State ZIP Code

RE: Disability Insurance Claim Appeal
Policy Number:
Claim Number:

Dear Claims Reviewer,

I am writing to formally appeal the decision to deny my disability insurance claim. I respectfully request a review of my claim based on the information provided below.

Explanation of Appeal:

Supporting Medical Information:

Enclosed Documents:

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Thank you for your attention to this matter. I look forward to your prompt response. If you need additional information, please contact me.

Sincerely,

Your Name