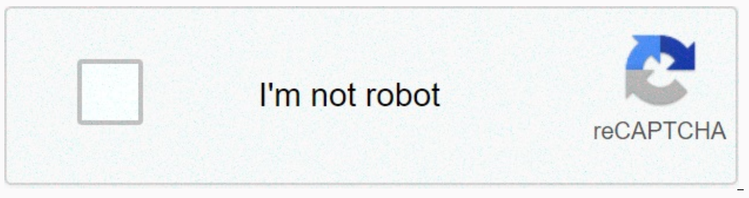

Continue

Disability insurance appeal letter template

People who think they are no longer physically or mentally able to work are applying for disability benefits. They search through the US Social Security Administration (SSA). When SSA submits a claim, the applicant has the right to submit a letter of complaint for disability. Format and content When you appeal any claim to a public body, it is necessary to provide as much information as possible so that the SSA representative can identify the correct requirement. The format of a letter of complaint for disabled people shall include your name, social security number, claim number, date you received the rejection letter and the reason for the rejection. It is also necessary to get the correct address and the name of a representative to whom your letter of complaint should be sent. Example When people applying for disability are denied benefits, it is often a good idea to file a complaint. This disability appeal letter sample is from a person who had a brain tumor. She has undergone surgery to remove the tumor. The operation was successful and the subsequent chemotherapy and radiotherapy were successful as well. However, the tumour and surgery left her with reduced hand-eye coordination, concentration problems and vision problems that have left her unable to maintain a job. She applied for a disability, was refused and is now appealing. Dear Mr. Drake, My name is Jennifer Long and I am writing to appeal my denial for disability benefit dated September 20, 2013. I applied because I have not been able to maintain a job since the operation to remove a brain tumor almost 2 years ago. I've tried extremely hard to work, but my eyesight is blurry and glasses don't help, my hand-eye coordination is very bad that prevents me from driving a vehicle, and I have enormous difficulty concentrating on tasks assigned to me. As a last resort, I applied for disability because I have 2 children, and my husband doesn't make enough money as a courier to support us all. We have had to borrow money from the family for a few months to pay rent and utilities. I have attached my medical records showing the damage done to my brain from the malignant tumor and the strong treatments. Also attached are results of tests showing my abnormal brain functions that have affected my hand-eye coordination, vision and ability to concentrate. There is also a letter from my doctor explaining that in his opinion I can not work. I have included my husband's W-2 form as well as showing his income last year and the number of hours he worked. Please reconsider my disability claim that you refused on September 20, 2013 using this additional information. I don't want anything better than to work, but my efforts over the last 2 years have been unsuccessful. Thank you for your time and consideration. Sincerely, Jennifer Long Jennifer S. Long I wrote this article for people who need to appeal a recent denial of long-term disability benefit. It gives you a 7-step process to make your internal appeal. Hsa insurance company denied the claim of long-term disability? Do you still get payments, but are worried that they may soon be cut off? Are you in panic mode wondering what your next move should be? If this sounds like you, you're in the right place. Appealing to your long-term disability denial is a seven-step process: For a broader review of long-term disability benefits, check out our Ultimate Guide to Long-term Disability in Canada. Step 1: Identify the deadline for appeal Nothing else matters if you miss the deadline to appeal. Some appeal deadlines are soft (no big deal), while other appeal deadlines are difficult (miss them and you're screwed). It's not easy to tell the difference, so work on the assumption that you have hard deadlines. So how do you know the deadline? If you received a letter from the insurance company that refused your claim (letter of denial), the appeal deadline is usually included in the final paragraphs of the letter. If the insurance company did not send a denial letter, and only informed you over the phone, you must ask them to put the denial in writing. The appeal deadline will either give you a specific date (e.g. April 2, 2020), or it will be stated as a certain number of days from the date of the rejection letter (e.g. 30 or 60 days). If you get a number of days, look at a calendar and count them out to find your deadline. Here is an example of what the appeal deadline looks like: In this example, the insurance company gives two deadlines: 30 days to give written notice of intent to appeal, and then a full 90 days to get all the documents to appeal. Step 2: Enforce your employment rights When your claim is denied, your insurance company will also send a letter to your employer. The company will tell your employer that you are able to work and do not qualify for long-term disability. When you receive this letter, your employer will probably call or write to you to ask when you plan to return to work. So, you must inform your employer, in writing, that you disagree with the insurance company and appeal their decision. Too many employers that's all you have to do. They will continue to allow you to be on unpaid sick leave while appealing for denial of long-term disability. However, some employers will take a more aggressive approach. They try to trust the insurance company's opinion that you can work, and demand that you return to work. They will warn that missing back to work will be seen as leaving your job, or something to that effect. If you are dealing with an aggressive employer, then you need to have your doctor write a new off-work note directly to them. This note or letter must clarify that the doctor continues to put you off work, regardless of the opinion of the insurance company. When you provide the employer with an updated sick note, it will trigger your rights to ongoing accommodation in accordance with and human rights laws. An affordable accommodation accommodation so that you can continue with unpaid sick leave. For more information see: Employment rights and disability benefit. Step 3: Collect documents needed to schedule your complaint You need information to understand denial and to plan your appeal. We recommend that you receive the following documents: A rejection letter from your claimRepresentationA copy of the group insurance booklet, which describes your long-term disability benefitsA copy of the insurance company's claim file (if your claim is more than six months old)Your union's collective agreement (if applicable)A copy of the family doctor's medical file goes back to when the symptoms began to affect your work The purpose of these documents is to help plan your complaint. However, your family doctor medical file also serves as proof of your claim. Make sure you have a clean copy of your family doctor's file to send to your insurance company. Step 4: Identify other benefits you can apply for It can take months to appeal a long-term disability denial. So you have to work on a plan B for other sources of income or financial support. You should consider whether you want to qualify for employment insurance (EI) sickness benefit or creditor disability benefit on bank loans or credit cards. Steps 5 and 6: Analyze the rejection letter and identify documents needed before the appeal Before you can plan your complaint strategy, you must first identify the insurance company's reasons for denial. Insurers are required to give reasons why they denied your claim. They're going to write these reasons for you. If you are lucky, your insurance company will provide very specific reasons for denial and may even list specific documents or information they need to reconsider their decision. Specific reasons are useful because they mention gaps in information from your doctors or information you have provided. This makes the appeal easier, because you know exactly what information to get them. The insurance company's reasons for denial often point to a gap in the information or medical opinions given. You can win the appeal by filling that gap. You can do this by providing missing information or medical documents to your insurance company. Common gaps that need to be filled include: clarifying a medical diagnosis that matches functional limitations exactly how your symptoms and limitations prevent you from doing your jobs or physical claims that provide copies of records or reports from other treatment providers' new medical evidence that proves information from colleagues or family members' work history Here's an example denial letter where company reasons are vague , but they provide specific recommendations for the documents needed on appeal: This kind of denial letter is useful because it gives the doctor specific questions to address in a new medical report that you can submit with the appeal. The inquiry asked to get his doctor to clarify the extent and severity of the diagnosis, prognosis, treatment plan, etc. It also requested a copy of the doctor's file from a specific date ahead. This is the easiest situation because you can give denial to your doctor and they can make a report that answers the questions and provide a copy of the file. Here's another example, where the cause of denial is, but the reference to the transferable skill assessment gives you something to focus on: In a situation like this, the insurance company does not note documents or information to provide on appeal. However, there is a clue as to how you can focus your appeal. If I advised a client, I would ask for a copy of the Transferable Skills Assessment (TSA) and look for ways to show that it was based on incorrect information, erroneous assumptions or poor judgment. For example, you can also have your doctor review the TSA and offer a critique. Or you can review the TSA and write a statement pointing to all the factual errors or misforections in the report. Often these TSAs are done without consultation with you, so they can be full of errors or factual errors. And finally, here is an example of the worst kind of justification for denial. That's what I call no-reason denial: As you can see, this letter gives no clear reasons, and therefore no details for you to focus on in your appeal. The insurance company did not say which specific gap in information led to the

denial. This denial mentions an earlier letter of denial, so I would start by looking at that letter to see if there was more specific information given therein. Another option is that you can ask your insurance company representative to give more detailed reasons, but they can't agree to do so. In a case like this, you may need to review your insurance company's claim file to see what's really going on. Sometimes in a no reason denial situation, the insurance company has completely closed its mind to approve your claim. The best option in this situation is often to just go ahead and take your appeal to court. Step 7: Prepare and send your letter of appeal I find that this last step – writing an appeal letter – causes people the most anxiety. You can feel that way, too. You worry that if you don't do a good job, it can lead to your claim being rejected. Let me calm your thoughts. In the vast majority of cases, the letter of appeal has almost no bearing on whether they will approve or deny your appeal. At this stage, the insurance company bases its decisions on the medical records and opinions you have submitted. Your appeal letter only needs to do three things: 1) Say you are asking for an appeal; 2) Attach the necessary documents in support of your appeal; and 3) Arrival to the insurance company before the deadline. Ideally, you will review the most important facts and then use the law to show why they should approve your claim, but I recommend against trying to do this Own. Hand. This type of letter of complaint is difficult to do – especially if you have no experience with a written advocate. I've seen more bad examples than good examples of people trying to do this. You are better off avoiding legal analysis and focusing on writing about any gaps in information. This may include: Clarifying any misconceptions about your medical care or employmentView all the things you did to try to stay at workExplanes how your symptoms affected your duties Once you have sent in your letter of appeal, you will usually get a response within 30 to 60 days. If there are delays, it is likely because the insurance company is waiting for its doctors to review the medical information you submitted. If your complaint is rejected, you may need to repeat this process again until you have exhausted all internal appeals or have the right to go to the next level of appeal. This next level of appeal could be an appeal hearing or an appeal in case of litigation. The rules that apply to you will depend on your insurance and collective agreement (if you are in a union). Next step Download our free checklist for disabled people and call our disability claims support team at 1-888-732-0470 for a free consultation and case review. We may use the checklist on your situation to develop a game plan for your appeal. Download our free handicap appeal checklist Follow the same steps our legal team used to win over 90% of the complaints for our customers. Subscribe to our newsletter by email (The Insider) and we'll send you a PDF copy of our checklist by email. Don't worry, we'll only send you one email per week (on Fridays) and you can unsubscribe at any time. Time.