[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Re: Notice of Long-Term Disability Claim Decision

Dear [Employee Name],

We are writing to inform you that your application for Long-Term Disability (LTD) benefits, submitted on [Date], has been denied.

After a thorough review of your claim file and the medical documentation provided by [Physician Name/Facility], it has been determined that you do not meet the definition of "disabled" as required by the [Plan Name] policy. Specifically, the evidence does not support a functional impairment that prevents you from performing the essential duties of your occupation beyond the required elimination period.

The specific reasons for this denial include:
[Insert specific medical or administrative reasons here]

You have the right to appeal this decision. If you disagree with this determination, you must submit a written request for an appeal within [Number] days of receiving this letter. Your appeal should include any additional medical records, diagnostic tests, or supporting statements you wish to be considered.

Please send your appeal to:
[Appeals Department Name]
[Address]
[City, State, Zip Code]

If you have any questions regarding this notice, please contact your case manager at [Phone Number].

Sincerely,

[Sender Name]
[Title]
[Company Name]