

[Your Name/Company Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Notice of Overpayment and Refund Request

Claim Number: [Insert Claim Number]
Policy Number: [Insert Policy Number]
Date of Incident: [Insert Date of Accident]
Insured Party: [Insert Name of Insured]

To Whom It May Concern,

This letter serves as a formal notice regarding an overpayment made in connection with the auto collision claim referenced above.

According to our records, a payment in the amount of \$[Insert Total Amount Paid] was issued on [Insert Date]. However, the actual amount due for this claim is \$[Insert Correct Amount Due]. This has resulted in an overpayment of \$[Insert Refund Amount].

The overpayment occurred due to:
[Insert Reason: e.g., Duplicate payment, calculation error, or adjustment in repair costs].

We kindly request that you issue a refund for the overpaid amount of \$[Insert Refund Amount] within [Insert Number, e.g., 14] business days. Please make the check payable to "[Insert Payee Name]" and mail it to the address listed at the top of this letter.

Included with this letter are the following supporting documents:

- [List Document 1, e.g., Repair Invoice]
- [List Document 2, e.g., Proof of Payment]

Thank you for your prompt attention to this matter. Please contact me at [Insert Phone Number] if you require additional information.

Sincerely,

[Your Signature]

[Your Printed Name]