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

[Date]

[Recipient Name]
[Recipient Title]
[Insurance Company Name]
[Company Address]
[City, State, Zip Code]

RE: Disability Insurance Coverage for [Policyholder Full Name]
Policy Number: [Your Policy Number]

Dear [Recipient Name/Claims Department],

I am writing to formally [apply for/inquire about] disability insurance benefits under the aforementioned policy. As the primary breadwinner for my household, the financial security of my family is dependent on my ability to earn an income. Due to a recent [injury/illness] that occurred on [Date], I am currently unable to perform the duties of my occupation.

My medical provider, [Doctor's Name], has diagnosed me with [Condition Name] and has advised that I am restricted from working for an estimated period of [Length of Time]. This loss of income poses a significant threat to our family's financial stability and our ability to meet essential living expenses.

Please find attached the following documentation to support this request:

- Completed Claim Form
- Attending Physician's Statement
- Employer Verification of Income and Duties
- Relevant Medical Records

I request that you process this claim as a priority to ensure the continued financial security of my dependents. Please notify me immediately if any additional information or documentation is required to complete the evaluation of this claim.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]