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

[Date]

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

RE: Notice of Good Faith Dispute
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Employer: [Company Name]

Dear [Claims Adjuster Name],

I am writing to formally dispute the denial of my workers' compensation claim dated [Date of Denial Letter]. The denial states that my claim was rejected on the basis that I am considered an independent contractor rather than an employee.

I am submitting this letter in good faith to request a reconsideration of this status. Under applicable state labor laws and the "Right to Control" test, I believe I qualify as an employee for the following reasons:

- [Reason 1: e.g., The company dictated my work hours and specific location.]
- [Reason 2: e.g., The company provided all necessary tools, equipment, and materials.]
- [Reason 3: e.g., My duties are a regular and integral part of the company's core business.]
- [Reason 4: e.g., I do not offer my services to the general public or operate a separate business entity.]

Attached are documents supporting my status as an employee, including [list attachments such as pay stubs, training manuals, or correspondence].

Please review this additional information and provide a written response regarding your decision to maintain or reverse the denial within [Number] days. I am committed to resolving this matter efficiently and am prepared to provide further documentation if necessary.

Sincerely,

[Your Signature]

[Your Printed Name]