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

[Date]

[Adjuster Name]
[Insurance Carrier Name]
[Claim Number]
[Address]
[City, State, Zip Code]

RE: Good Faith Dispute of Claim Denial / Incorrect Wage Calculation
Date of Injury: [Date]
Employer: [Employer Name]

Dear [Adjuster Name],

I am writing this letter in good faith to formally dispute the denial of my workers' compensation benefits and/or the calculation of my Average Weekly Wage (AWW). I believe the current determination does not accurately reflect my total earnings and benefits as required by state law.

I am disputing the current valuation based on the following omitted items:

- [Insert specific item, e.g., Unpaid Overtime Hours]
- [Insert specific item, e.g., Performance Bonuses or Commissions]
- [Insert specific item, e.g., Value of Employer-Provided Housing or Vehicle]
- [Insert specific item, e.g., Health Insurance Premium Contributions]

Attached to this letter, please find documentation supporting my claim, including [list attachments, e.g., pay stubs, tax forms, or employment contracts]. These records demonstrate that my actual earnings prior to the injury were [Insert Correct Amount] per week, rather than the amount currently cited in your records.

I request that you review this additional information and adjust my benefit rate accordingly. I am interested in resolving this discrepancy promptly and in good faith to avoid further administrative hearings or litigation.

Please provide a written response regarding your decision on this matter within [Insert Number of Days, e.g., 10] business days.

Sincerely,

[Your Signature]

[Your Printed Name]