

[Sender's Name/Insurance Agency]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

Dear [Policyholder Name],

Welcome to [Insurance Company Name]! We are pleased to provide your Medicare Supplement insurance coverage. This policy is designed to help cover costs that Original Medicare does not pay, such as copayments, coinsurance, and deductibles.

Your Coverage Details:

- **Plan Type:** Medicare Supplement [Plan Letter, e.g., Plan G]
- **Policy Number:** [Policy Number]
- **Effective Date:** [Date Coverage Begins]
- **Monthly Premium:** [Amount]

Key Benefits of Your Plan:

- Freedom to choose any doctor or hospital that accepts Medicare.
- No referrals required to see a specialist.
- Guaranteed renewable coverage as long as premiums are paid on time.
- Coverage travels with you anywhere in the United States.

Next Steps:

Please review your enclosed Policy Identification Card and keep it in your wallet. Present this card along with your Red, White, and Blue Medicare card whenever you receive medical services.

If you have any questions regarding your benefits, claims, or billing, please contact our customer service department at [Phone Number] or visit our website at [Website URL].

Thank you for choosing [Insurance Company Name] for your healthcare needs.

Sincerely,

[Signature/Name]
[Title]