

[Date]

[Policyholder Name]

[Address Line 1]

[Address Line 2]

[City, State, Zip Code]

Re: Dental and Vision Coverage - Policy Number: [Policy Number]

Dear [Policyholder Name],

Thank you for choosing [Insurance Company Name] for your health coverage needs. We are writing to provide you with important information regarding your individual Dental and Vision insurance policy.

Your coverage is currently active. Below is a summary of your plan benefits:

- **Dental Coverage:** Includes routine cleanings, X-rays, and [Basic/Major] restorative services.
- **Vision Coverage:** Includes annual eye exams, and an allowance for frames, lenses, or contact lenses.
- **Effective Date:** [Start Date]
- **Network:** [Network Name]

To view your full schedule of benefits or to find a provider within our network, please log in to your member portal at [Website URL] or use our mobile app.

Enclosed you will find your new member ID cards. Please present these cards at the time of your appointment to ensure your claims are processed correctly.

If you have any questions regarding your benefits, please contact our Customer Service department at [Phone Number] or email us at [Email Address].

Sincerely,

[Sender Name/Department]

[Insurance Company Name]