[Date]

[Member Name]
[Address Line 1]
[City, State, Zip Code]

Subject: Important Information Regarding Your Dental and Vision Gap Coverage

Dear [Member Name],

Thank you for enrolling in [Company Name]. This letter confirms your post-enrollment dental and vision gap coverage, effective [Start Date] through [End Date].

This temporary coverage is designed to ensure you have access to essential care while your primary plan transition is finalized. Below are your coverage details:

- **Policy Number:** [Policy Number]
- **Dental Coverage:** [Summary of Benefits, e.g., Preventative and Basic services]
- **Vision Coverage:** [Summary of Benefits, e.g., Annual exam and lens allowance]
- **Provider Network:** [Network Name]

To use your benefits, please present this letter or your digital ID card at the time of your appointment. You can find a participating provider by visiting [Website URL] or calling our member services line at [Phone Number].

Please note that this gap coverage will automatically terminate once your permanent plan becomes active on [Permanent Plan Start Date]. No further action is required on your part.

If you have any questions regarding your benefits or need assistance locating a provider, please contact us at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]
[Title]
[Company Name]