[Company Name]
[Company Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Policy Change and Premium Adjustment Invoice
Policy Number: [Policy Number]
Effective Date of Change: [Effective Date]

Dear [Policyholder Name],

This letter is to confirm the recent change made to your insurance policy. As requested, your deductible has been decreased from $[Old Deductible Amount] to $[New Deductible Amount].

Because a lower deductible increases the portion of risk covered by the insurer, this change has resulted in a premium adjustment. Please find the invoice details below:

- **Previous Annual Premium:** $[Amount]
- **New Annual Premium:** $[Amount]
- **Pro-rated Additional Premium Due:** $[Amount]
- **Payment Due Date:** [Date]

Please remit your payment by the due date mentioned above to ensure your coverage remains active. You may pay via [Payment Methods, e.g., online portal, check, or phone].

Revised policy documents reflecting your new deductible level are enclosed with this letter. Please review them carefully and keep them for your records.

If you have any questions regarding this adjustment or your coverage, please contact our customer service department at [Phone Number] or [Email Address].

Sincerely,

[Name/Signature]
[Title]
[Company Name]