[Company Name/Insurance Provider]
[Department Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

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

Subject: Confirmation of Health Insurance Coverage Limit Decrease

Dear [Policyholder Name],

This letter is to formally confirm that we have processed your request to decrease the coverage limits on your health insurance policy, effective [Effective Date].

Policy Details:

- Policy Number: [Policy Number]
- Previous Coverage Limit: $[Amount]
- New Coverage Limit: $[Amount]
- New Monthly Premium: $[Amount]

The changes reflect the adjustments you requested on [Date of Request]. Please review the enclosed Summary of Benefits for a detailed breakdown of your updated coverage and any changes to your out-of-pocket maximums or co-payments.

Please note that this change may affect your financial responsibility for medical services rendered after the effective date mentioned above. Your updated insurance identification cards will be mailed to you within [Number] business days.

If you have any questions regarding this change or did not authorize this request, please contact our Customer Service Department immediately at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Name of Representative]
[Title]
[Company Name]