[Date]

[Applicant Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

Subject: Delivery of Your Medicare Supplement Insurance Policy

Dear [Applicant Name],

Thank you for choosing [Insurance Company Name] for your Medicare Supplement insurance needs. We are pleased to inform you that your application has been approved.

Please find your enclosed policy, number [Policy Number], with an effective date of [Effective Date].

Important Information:

- **Review Your Policy:** Please review the attached document carefully to ensure all information is correct and that you understand your coverage and benefits.
- **Right to Return (Free Look Period):** You have [30 days] from the date you receive this policy to examine it. If you are not satisfied for any reason, you may return it to us or your agent. Any premiums paid will be refunded in full, and the policy will be considered void from the beginning.
- **Policy ID Card:** Your permanent identification card is included. Please carry this card with you and present it to your healthcare providers along with your Medicare card.

If you have any questions regarding your coverage, please contact your agent, [Agent Name], at [Agent Phone Number], or call our Customer Service Department at [Customer Service Phone Number].

We appreciate the opportunity to serve you.

Sincerely,

[Sender Name/Signature]
[Title]
[Insurance Company Name]

Enclosures: Medicare Supplement Policy, ID Card