[Date]

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

Re: Your New Medicare Supplement Insurance Policy

Dear [Applicant Name],

Welcome to [Company Name]. We are pleased to inform you that your application for a Medicare Supplement insurance policy has been approved following our underwriting review. Your coverage is effective as of [Effective Date].

Please find your enclosed policy documents, including your Policy Schedule and ID card. We encourage you to review these documents carefully to ensure you understand your benefits and coverage limits.

Important Information:

- **Policy Number:** [Policy Number]
- **Plan Type:** [Plan Letter, e.g., Plan G]
- **Premium Amount:** [Premium Amount] per [Frequency]
- **Right to Return (Free Look Period):** You have 30 days from the date you receive this policy to review it. If you are not satisfied for any reason, you may return it to us for a full refund of any premiums paid.

Please keep your ID card in your wallet and present it to your healthcare providers along with your Medicare card to ensure proper billing.

If you have any questions regarding your new policy or need to update your contact information, please contact our Customer Service Department at [Phone Number] or visit our website at [Website URL].

Thank you for choosing [Company Name] for your supplemental healthcare needs.

Sincerely,

[Signature]
[Name of Representative/Department]
[Company Name]