[Agent or Company Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

[Date]

[Applicant Name]
[Address Line 1]
[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 needs. Enclosed is your new insurance policy for [Plan Letter, e.g., Plan G].

This policy was issued under **Guaranteed Issue** rights. This means that your coverage was approved without the requirement of medical underwriting or a waiting period for pre-existing conditions, based on your qualifying event.

Important Information:

- **Policy Number:** [Policy Number]
- **Effective Date:** [Effective Date]
- **Monthly Premium:** [Premium Amount]

Please review your policy carefully to ensure all information is correct. You have a "30-Day Free Look Period" starting from the date you receive this policy. If you are not satisfied for any reason, you may return the policy within 30 days for a full refund of any premiums paid.

Your member ID card is [enclosed / will arrive in a separate mailing]. Please present this card along with your Red, White, and Blue Medicare card whenever you receive medical services.

If you have any questions or require assistance, please contact me directly at [Agent Phone Number] or call our customer service department at [Customer Service Number].

Sincerely,

[Agent Signature]

[Agent Printed Name]
[License Number]