[Date]

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

Subject: Delivery of Your Medicare Supplement Insurance Policy

Dear [Applicant Name],

Welcome to [Insurance Company Name]. We are pleased to provide you with your new Medicare Supplement insurance policy, number [Policy Number]. This policy was issued during your Open Enrollment period, ensuring your acceptance without medical underwriting.

Enclosed you will find the following important documents:

- Your original insurance policy
- Your insurance identification card
- A copy of your signed application
- An Outline of Coverage

Please review your policy immediately. You have a "Free Look" period of 30 days from the date you receive this policy. If you are not satisfied for any reason, you may return the policy to us within 30 days for a full refund of any premiums paid.

Your coverage is scheduled to begin on [Effective Date]. Please present your new insurance ID card along with your Red, White, and Blue Medicare card whenever you visit a healthcare provider.

If you have any questions regarding your benefits or if any information on your policy is incorrect, please contact your agent, [Agent Name], at [Agent Phone Number], or call our Member Services department at [Customer Service Number].

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

Sincerely,

[Sender Name]
[Title]
[Insurance Company Name]