[Date]

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

Subject: Delivery of Your Replacement Medicare Supplement Insurance Policy

Dear [Applicant Name],

Thank you for choosing [Insurance Company Name] for your healthcare coverage. Enclosed is your new Medicare Supplement insurance policy, policy number [Policy Number].

Because this policy replaces your previous coverage, please review the following important information:

- **30-Day 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 within 30 days for a full refund of any premiums paid.
- **Effective Date:** Your new coverage begins on [Effective Date].
- **Termination of Old Policy:** Please ensure your previous Medicare Supplement policy is cancelled as of the effective date of this new policy to avoid duplicate billing.
- **Benefits and Coverage:** This policy provides the benefits outlined in the Plan [Plan Letter] summary. Please keep this document in a safe place.

Your new identification card is included with this package. Please present this card along with your Medicare card to your healthcare providers.

If you have any questions regarding your new coverage or the transition from your previous policy, please contact your agent, [Agent Name], at [Agent Phone Number], or call our customer service department at [Customer Service Number].

Sincerely,

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