[Date]

[Policyholder Name]
[Address Line 1]
[Address Line 2]

Re: Policy Number: [Policy Number]

Dear [Policyholder Name],

Thank you for choosing [Insurance Company Name] for your Medicare Supplement needs. We are pleased to enclose your new High Deductible [Plan G/F] Medicare Supplement insurance policy.

Important Information Regarding Your High Deductible Plan:

- **Annual Deductible:** This policy has a high deductible requirement of $[Current Year Deductible Amount]. You must pay out-of-pocket costs (coinsurance, copayments, and deductibles) until the annual deductible is met before the policy begins to pay benefits.
- **Effective Date:** Your coverage is effective as of [Effective Date].
- **Review Period:** You have a 30-day "Free Look" period. If you are not satisfied with this policy for any reason, you may return it within 30 days of receipt for a full refund of any premiums paid.

Please review your policy document carefully and keep it in a safe place. It contains important details regarding your coverage, exclusions, and claim procedures.

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

Sincerely,

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