[Agent Name]
[Agent Address]
[City, State, Zip]
[Phone Number]

[Date]

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

Re: Medicare Supplement Policy Number: [Policy Number]

Dear [Client Name],

Enclosed is your new Medicare Supplement insurance policy issued by [Insurance Company Name]. I am pleased to hand-deliver this document to ensure you have everything you need for your coverage.

Please review your policy carefully. It is important to keep this document in a safe place along with your other healthcare records. This policy is designed to help cover costs that Original Medicare does not, such as copayments, coinsurance, and deductibles.

Key Information:

- **Policy Effective Date:** [Effective Date]
- **Plan Type:** [Plan Letter/Name]
- **Premium Amount:** [Premium Amount]
- **Premium Due Date:** [Due Date]

Right to Return (Free Look Period):
You have a 30-day "Free Look" period starting from today. If you are not satisfied with the policy for any reason, you may return it within 30 days for a full refund of any premiums paid.

I have also enclosed a **Policy Delivery Receipt**. Please sign and date one copy for my records to confirm that you have received your policy today.

Thank you for trusting me with your insurance needs. If you have any questions or need to make changes in the future, please contact me directly at [Agent Phone Number].

Sincerely,

[Agent Signature]

[Agent Printed Name]