[Date]

[Insured Name]
[Practice Name]
[Address Line 1]
[City, State, Zip Code]

RE: Medical Professional Liability Policy Delivery
Policy Number: [Policy Number]
Policy Period: [Start Date] to [End Date]

Dear [Dr. Last Name / Name of Insured],

Enclosed please find your Medical Professional Liability insurance policy. We recommend that you review this document thoroughly to ensure that the limits, coverage terms, and retroactive dates accurately reflect your practice requirements.

Please pay particular attention to the following sections:

- **Declarations Page:** Outlines your coverage limits and premium.
- **Exclusions:** Details specific procedures or conditions not covered.
- **Reporting Requirements:** Instructions on how and when to report a potential claim or incident.

Please keep this policy in a secure location. If you have any questions regarding your coverage or if there are changes to your medical practice, such as a change in scope of services or location, please contact our office immediately.

Thank you for choosing [Insurance Company/Agency Name] for your professional liability needs.

Sincerely,

[Your Name]
[Title]
[Company Name]
[Phone Number]