Insurance Co-Payment Information for Dependent Coverage

Date: [Insert Date]

To: [Recipient Name]

[Recipient Address]

Dear [Recipient Name],

We are pleased to provide you with the co-payment information for your dependent coverage under our insurance plan. Below are the details regarding your co-payments:

Dependent Information

Name of Dependent: [Dependent Name]

Date of Birth: [DOB]

Co-Payment Details

Service Type	Co-Payment Amount
Primary Care Visit	$[Amount]
Specialist Visit	$[Amount]
Emergency Room Visit	$[Amount]

If you have any further questions regarding your co-payment details or any other insurance inquiries, please feel free to contact us at [Insurance Company Phone Number] or [Insurance Company Email Address].

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

Sincerely,

[Your Name]

[Your Title]

[Insurance Company Name]

[Insurance Company Address]