[Date]

[Member Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

Subject: Important Notice Regarding Your Health Insurance Coverage

Dear [Member Name],

We are writing to inform you that [Insurance Company Name] will no longer offer your current health insurance plan, [Current Plan Name], effective [End Date]. Your coverage under this plan will end on that date.

Why is this happening?
We have decided to discontinue this specific plan as part of our efforts to update our product offerings and comply with changing market regulations.

What does this mean for you?
To ensure you remain covered, you must select a new health plan. If you do not enroll in a new plan by [Enrollment Deadline], your health insurance coverage will lapse on [End Date].

Your options for new coverage:

- **Automatic Enrollment:** If you do not take action, we will automatically enroll you in [Alternative Plan Name], which is the plan most similar to your current one. This change would begin on [Start Date].
- **Choose a Different Plan:** You can browse other plans we offer or visit the Health Insurance Marketplace at [Website URL] to compare different providers.

Key Dates to Remember:

- [End Date]: Your current plan expires.
- [Start Date]: Your new coverage begins.
- [Deadline Date]: The last day to change your plan selection.

We are here to help you through this transition. If you have any questions regarding your new plan options, premium costs, or benefits, please call our Member Services department at [Phone Number] or visit our website at [Website URL].

Thank you for being a valued member.

Sincerely,

[Name/Department]
[Insurance Company Name]