Date: [Insert Date]

To:
[Policyholder Name]
[Address Line 1]
[City, State, Zip Code]

Subject: Notice of Health Insurance Cancellation for Non-Payment of Premium

Policy Number: [Insert Policy Number]

Dear [Policyholder Name],

Our records indicate that we have not received the premium payment for the health insurance policy referenced above. As of [Date], your account is past due in the amount of $[Amount Due].

Please be advised that your health insurance coverage will be **canceled** effective [Termination Date] if the full balance is not received by [Due Date/Grace Period End Date].

If your coverage is canceled:

- You will no longer have health insurance protection through this policy.
- Any medical claims incurred after the termination date will not be paid.
- You may lose the opportunity to re-enroll until the next Open Enrollment period.

To keep your coverage active, please submit your payment immediately via one of the following methods:

- **Online:** [Insert Website URL]
- **Phone:** [Insert Phone Number]
- **Mail:** [Insert Mailing Address for Payments]

If you have already sent your payment, please disregard this notice. If you believe this notice was sent in error, or if you are experiencing financial hardship, please contact our Customer Service department at [Insert Phone Number] immediately.

Sincerely,

[Sender Name/Department]
[Insurance Company Name]