

Date: [Insert Date]

Recipient Name: [Insert Policyholder Name]

Address: [Insert Street Address]

City, State, Zip: [Insert City, State, Zip]

**Subject: FINAL NOTICE: Urgent - Pending Cancellation of Health Insurance Policy
#[Insert Policy Number]**

Dear [Insert Policyholder Name],

This is a formal and final notice regarding the status of your health insurance policy. Our records indicate that we have not received the outstanding payment required to keep your coverage active.

Account Summary:

- **Policy Number:** [Insert Policy Number]
- **Past Due Amount:** \$[Insert Amount]
- **Due Date to Avoid Cancellation:** [Insert Date]

Please be advised that if the full payment is not received by **[Insert Date]**, your health insurance coverage will be terminated effective **[Insert Cancellation Effective Date]**.

Consequences of Cancellation:

- Loss of all medical, dental, and vision benefits provided under this policy.
- Responsibility for the full cost of any medical services received after the cancellation date.
- Potential waiting periods or higher premiums if you seek to reinstate coverage or apply for a new policy in the future.

If you have already sent your payment, please disregard this notice. If you believe this notice has been sent in error, or if you are experiencing financial hardship and wish to discuss a payment plan, please contact our Billing Department immediately at [Insert Phone Number].

To ensure your coverage remains uninterrupted, you may pay online at [Insert Website URL] or by calling [Insert Payment Phone Number].

Sincerely,

[Insert Sender Name/Department]

[Insert Insurance Company Name]

[Insert Contact Information]