[Date]

[Policyholder Name]
[Street Address]
[City, State, Zip Code]

Re: Notice of Insurance Policy Cancellation

Policy Number: [Policy Number]
Product Type: [Health Insurance Plan Name]

Dear [Policyholder Name],

This letter serves as official confirmation that your health insurance coverage has been cancelled due to non-payment of premiums.

Our records indicate that the grace period for your past-due premium payment expired on [Date]. As we did not receive the required payment by this deadline, your policy was terminated effective [Effective Date of Cancellation].

Please be advised of the following:

- **Coverage Status:** You no longer have health insurance coverage through this policy. Any medical services received after the effective date of cancellation will not be covered.
- **Claims:** Any claims submitted for services rendered after the cancellation date will be denied.
- **Outstanding Balance:** You remain responsible for any unpaid premiums owed for the period your coverage was active.

If you believe this cancellation was made in error, or if you wish to discuss reinstatement options (if available), please contact our Customer Service Department immediately at [Phone Number] or visit [Website Address].

Sincerely,

[Sender Name/Department]
[Insurance Company Name]