

Date: [Insert Date]

Recipient Name: [Insert Policyholder Name]

Address: [Insert Address]

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

Policy Number: [Insert Policy Number]

NOTICE OF TERMINATION OF HEALTH INSURANCE COVERAGE

Dear [Insert Policyholder Name],

This letter serves as formal notification that your health insurance coverage under the policy listed above has been cancelled effective **[Insert Cancellation Date]**.

On [Insert Date of Previous Notice], we informed you that your premium payment was past due and that your account had entered a grace period. As of the date of this letter, we have not received the required payment of **[\$[Insert Total Amount Due]** to bring your account current.

Impact of Cancellation:

- Your healthcare coverage is no longer active.
- Any claims for services provided after [Insert Cancellation Date] will be denied.
- You may be responsible for the full cost of any medical services received after the termination date.

Reinstatement Options:

If you wish to appeal this cancellation or inquire about reinstating your coverage, please contact our Member Services Department immediately at [Insert Phone Number]. Reinstatement is subject to company policy and is not guaranteed.

Other Coverage Options:

You may be eligible to purchase a new plan through the Health Insurance Marketplace. Typically, losing existing coverage qualifies you for a Special Enrollment Period.

Sincerely,

[Insert Name/Department]

[Insert Insurance Company Name]

[Insert Contact Information]