[Insurance Company Name]
[Billing Department Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: PAST DUE NOTICE - Policy Number: [Policy Number]

Dear [Policyholder Name],

This is a formal notification that your health insurance premium payment for the period of [Billing Period] was not received by the due date of [Original Due Date].

Status of Your Coverage:
Your account is now in a grace period. According to your policy terms, you have [Number of Days, e.g., 30] days from the original due date to pay your premium in full to keep your coverage active.

Payment Required:
To avoid the cancellation of your health insurance coverage, please submit the following amount immediately:

- Past Due Amount: $[Amount]
- Late Fees (if applicable): $[Amount]
- **Total Amount Due: $[Total Amount]**

Deadline:
Your payment must be received no later than **[Grace Period End Date]**. If payment is not received by this date, your health insurance policy will be terminated effective [Termination Date], and any claims incurred after this date will not be covered.

How to Pay:
- Online: [Website URL]
- Phone: [Phone Number]
- Mail: Please use the enclosed payment voucher.

If you have already sent your payment, please disregard this notice. If you are experiencing financial hardship or have questions regarding your bill, please contact our Customer Service department at [Phone Number] as soon as possible.

Sincerely,

[Name/Department]
[Insurance Company Name]