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

[Date]

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

RE: NOTICE OF HEALTH INSURANCE POLICY LAPSE

Policy Number: [Policy Number]
Total Past Due Amount: $[Amount]
Termination Effective Date: [Date]

Dear [Policyholder Name],

This letter serves as formal notification that your health insurance coverage under the policy listed above has lapsed effective [Date] due to non-payment of premiums.

Our records indicate that your account is delinquent in the amount of $[Amount], which represents unpaid premiums for the following period(s): [List Months/Dates].

What this means for you:
As of the termination date, you no longer have health insurance coverage through [Company Name]. Any medical claims incurred after this date will be your personal financial responsibility and will not be paid by this plan.

How to reinstate your coverage:
You may be eligible to reinstate your policy if the total past due balance is paid in full by [Reinstatement Deadline Date]. Please note that reinstatement is subject to company approval and may require a reinstatement fee.

To make a payment, please use one of the following methods:
- Online: [Website URL]
- Phone: [Phone Number]
- Mail: Send a check to the address listed at the top of this letter.

If you have already mailed your payment, please disregard this notice. If you believe this notice was sent in error or if you wish to discuss payment arrangements, please contact our Customer Service Department immediately at [Phone Number].

Sincerely,

[Sender Name/Department]
[Company Name]