Date: [Insert Date]

[Policyholder Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

Subject: NOTICE OF POLICY LAPSE - Policy Number: [Insert Policy Number]

Dear [Policyholder Name],

This letter is to formally notify you that your Workers' Compensation insurance policy has lapsed effective **[Insert Lapse Date]** due to non-payment of scheduled installments.

As of this date, your coverage is no longer active. Please be aware of the following:

- **No Coverage:** Any work-related injuries or illnesses occurring after the lapse date will not be covered by this policy.
- **Legal Requirements:** Most states require employers to maintain continuous Workers' Compensation insurance. Operating without coverage may result in significant legal penalties, fines, or stop-work orders.
- **Outstanding Balance:** The total amount currently past due is **$[Insert Amount]**.

How to Reinstate Your Coverage:

To discuss the possibility of reinstating your policy, you must pay the outstanding balance immediately. Please contact our Billing Department at [Insert Phone Number] or visit our online portal at [Insert Website URL].

Please note that reinstatement is not guaranteed and may be subject to a "No Loss Statement" confirming no claims occurred during the lapse period.

If you have already sent your payment, please disregard this notice.

Sincerely,

[Sender Name/Department]
[Insurance Company Name]
[Contact Phone Number]