URGENT: IMMEDIATE ACTION REQUIRED

Date: [Insert Date]

To: [Recipient Name]
Policy Number: [Insert Policy Number]
Subject: Notice of Policy Lapse and Requirements for Reinstatement

Dear [Recipient Name],

Our records indicate that your policy, [Policy Number], has lapsed effective [Date of Lapse] due to [Reason, e.g., non-payment of premium]. As a result, your coverage is no longer active.

To avoid a permanent termination of your benefits and to reinstate your coverage, you must take the following actions immediately:

- **Payment:** Submit a payment of $[Amount] by [Deadline Date].
- **Documentation:** Complete and return the enclosed [Name of Form/Statement of Good Health].
- **Verification:** [Optional: List any other specific requirement].

Please note that coverage is not guaranteed until your application for reinstatement has been reviewed and approved by our underwriting department. Any claims incurred during the lapse period may not be covered.

You can make your payment via [Payment Method/Website] or by calling our billing department at [Phone Number].

If you have already sent your payment or believe this notice is in error, please contact us immediately at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]
[Title]
[Company Name]