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

Date: [Date]

Policyholder Name: [Policyholder Name]
Policy Number: [Policy Number]
Policy Type: Medicare Supplement [Plan Letter]

Subject: NOTICE OF TERMINATION - PAST DUE PREMIUM

Dear [Policyholder Name],

Our records indicate that we have not received the premium payment for your Medicare Supplement insurance policy. As a result, your coverage has lapsed effective **[Termination Date]**.

Current Status: Your policy is no longer active. Claims for medical services provided after the termination date listed above will not be covered by this policy.

Reinstatement Period: You may be eligible to reinstate your coverage without a gap in protection if we receive your payment of **$[Total Amount Due]** by **[Reinstatement Deadline Date]**.

If you have already mailed your payment, please disregard this notice. If you believe this notice was sent in error, or if you are experiencing a hardship due to a cognitive impairment or functional incapacity, please contact our Customer Service department immediately.

How to Pay:
1. Online: [Website URL]
2. Phone: [Phone Number]
3. Mail: Send a check to the address listed above.

Sincerely,

[Sender Name/Department]
[Company Name]