URGENT: NOTICE OF POLICY LAPSE

Date: [Insert Date]

[Policyholder Name]
[Address Line 1]
[Address Line 2]

Policy Number: [Insert Policy Number]

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 lapsed on **[Insert Lapse Date]**.

This means you currently do not have supplemental coverage for expenses not paid by Original Medicare, such as copayments, coinsurance, and deductibles. To protect your healthcare coverage and avoid the need for medical underwriting, it is critical that you take action immediately.

How to Reinstate Your Coverage:

- **Total Amount Due:** $[Insert Amount]
- **Due Date for Reinstatement:** [Insert Grace Period End Date]

Please send your payment immediately using one of the following methods:

- **Phone:** Call us at [Insert Phone Number] to pay by credit card or bank draft.
- **Online:** Visit [Insert Website URL] and log into your account.
- **Mail:** Send a check to [Insert Mailing Address].

If your payment has already been sent, please disregard this notice. If you have any questions or are experiencing a financial hardship, please contact our customer service department at [Insert Phone Number] to discuss your options.

Sincerely,

[Name/Department]
[Insurance Company Name]