

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

[Date]

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

## **FINAL NOTICE: TERMINATION OF COVERAGE**

Re: Medicare Supplement Policy #[Policy Number]

Dear [Policyholder Name],

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

### **What this means for you:**

Your policy is no longer active. You are currently responsible for any medical costs that Medicare does not cover, such as deductibles, copayments, and coinsurance. Claims for services received after [Termination Date] will not be paid by this policy.

### **To Reinstate Your Coverage:**

You may still be able to reinstate your policy if payment is received by [Reinstatement Deadline Date]. To prevent a permanent loss of coverage, please pay the total outstanding balance immediately:

**Total Amount Due: \$[Amount]**

**Due Date: [Date]**

Payments can be made via [Payment Methods, e.g., phone, online portal, or mail].

If you have already sent your payment, please disregard this notice. If you believe this notice was sent in error, or if you are experiencing a hardship that prevents payment, please contact our Customer Service Department immediately at [Phone Number].

Sincerely,

[Department Name]  
[Insurance Company Name]