

IMPORTANT NOTICE: NOTICE OF TERMINATION OF COVERAGE

Date: [Insert Date]

Policyholder Name: [Insert Name]

Policy Number: [Insert Policy Number]

Address: [Insert Address]

Dear [Insert Policyholder Name],

This letter is to officially notify you that your Medicare Supplement (Medigap) insurance policy has lapsed effective [Insert Date of Termination] due to non-payment of premiums.

As of the date above, your coverage is no longer active. This means that [Company Name] will not be responsible for paying any medical expenses or supplemental costs incurred after the termination date. You are now responsible for any deductibles, coinsurance, or copayments that your Medicare Supplement policy previously covered.

Reason for Lapse:

Non-payment of premium for the period of [Insert Billing Period].

How to Reinstate Your Coverage:

In some cases, you may be eligible to reinstate your policy if you take action immediately. To avoid a permanent loss of coverage or the requirement of new medical underwriting, please complete the following:

- Submit the past-due premium amount of \$[Insert Amount] by [Insert Deadline Date].
- Contact our Billing Department at [Insert Phone Number].

If you have already mailed your payment, please disregard this notice. If you believe this termination is in error, please contact our Customer Service Department at [Insert Customer Service Phone Number] immediately.

Thank you for your prompt attention to this matter.

Sincerely,

[Insert Name/Department]

[Insert Insurance Company Name]