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

[Date]

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

Subject: NOTICE OF TERMINATION - Medicare Supplement Policy #[Policy Number]

Dear [Policyholder Name],

We are writing to inform you that your Medicare Supplement insurance policy has lapsed and coverage has been terminated effective [Termination Date].

Our records show that the grace period for your unpaid premium of $[Amount Due], originally due on [Original Due Date], has expired. Because the payment was not received by the end of the grace period, your benefits under this policy have ended.

What this means for you:
Medical services received after [Termination Date] will not be covered by this policy. You are now responsible for any deductibles, copayments, or coinsurance that Medicare does not pay.

Reinstatement Options:
You may be eligible to reinstate your coverage if you act quickly. To request reinstatement, please:

- Submit the full past-due amount of $[Amount Due] immediately.
- Contact our Customer Service department at [Phone Number] to discuss reinstatement requirements.

Please note that reinstatement may be subject to underwriting approval or specific state regulations. If you have already mailed your payment, please disregard this notice.

Sincerely,

[Sender Name/Department]
[Company Name]