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

Date: [Current Date]

Policyholder Name: [Member Name]
Policy Number: [Policy Number]
Notice Type: URGENT - ACTION REQUIRED

Dear [Member Name],

Our records indicate that we have not received the premium payment for your Medicare Supplement insurance policy. As a result, your coverage is currently in a grace period and is at risk of lapsing.

Status Details:

- **Past Due Amount:** $[Amount]
- **Due Date:** [Date]
- **Coverage Termination Date:** [Date]

To keep your coverage active and avoid a lapse in benefits, we must receive your payment by [Termination Date]. If payment is not received by this date, your policy will be cancelled effective [Effective Date of Cancellation].

How to Pay:

- **By Phone:** Call [Phone Number] to pay via credit card or bank draft.
- **Online:** Visit [Website URL] to log into your account.
- **By Mail:** Send a check using the enclosed envelope to [Mailing Address].

If you have already sent your payment, please disregard this notice. If you are experiencing financial hardship or have questions regarding your billing, please contact our Customer Service department immediately at [Phone Number].

Maintaining your Medicare Supplement policy is important for covering costs that Original Medicare does not pay. We value your membership and want to help you maintain your coverage.

Sincerely,

[Sender Name/Department]
[Company Name]