IMPORTANT NOTICE: MEDICARE SUPPLEMENT POLICY LAPSE

Date: [Date]

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

Policy Number: [Policy Number]

Dear [Policyholder Name],

This letter is to inform you that your Medicare Supplement insurance coverage has lapsed effective [Date] due to non-payment of premiums.

As a result of this lapse, you no longer have coverage for the gaps in your Medicare Part A and Part B costs. Any medical services received after the effective date mentioned above will not be covered by this policy.

How to Reinstate Your Coverage:

You may be eligible to reinstate your policy if you take action immediately. To prevent a permanent loss of coverage, please follow these steps:

- Submit the past due premium amount of $[Amount] by [Deadline Date].
- Contact our Billing Department at [Phone Number] to confirm payment receipt.

If payment is not received by the deadline stated above, you may be required to re-apply for coverage, which may involve medical underwriting or higher premium rates.

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 financial hardship, please contact our Customer Service team at [Phone Number] between [Hours of Operation].

Sincerely,

[Company Name]
[Department Name]
[Contact Information]