URGENT: NOTICE OF TERMINATION OF COVERAGE

Date: [Insert Date]

Policyholder Name: [Insert Name]
Policy Number: [Insert Policy Number]
Plan Type: [Insert Plan Letter, e.g., Plan G]

Dear [Insert Policyholder Name],

This letter serves as formal notification that your Medicare Supplement insurance coverage has been cancelled effective **[Insert Cancellation Date]** due to non-payment of premiums.

Our records indicate that the required premium payment for the period of [Insert Period] was not received within the 30-day grace period. Consequently, your policy has lapsed and is no longer active. Any medical claims incurred after the cancellation date will not be covered by this policy.

Reinstatement Options:

You may be eligible to reinstate your coverage if you take action immediately. To request reinstatement, please follow these steps:

- Submit the past-due premium amount of $[Insert Amount] by [Insert Deadline Date].
- Complete the enclosed Reinstatement Application (if applicable).
- Contact our Billing Department at [Insert Phone Number].

Please note that reinstatement is subject to company approval and may require evidence of insurability depending on the duration of the lapse.

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

Sincerely,

[Insert Name/Department]
[Insert Insurance Company Name]