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

Date: [Current Date]

Policyholder Name: [Policyholder Name]
Policy Number: [Policy Number]
Subject: NOTICE OF POLICY LAPSE AND REINSTATEMENT RIGHTS

Dear [Policyholder Name],

This letter is to inform you that your Medicare Supplement insurance policy lapsed on [Lapse Date] due to non-payment of premiums. As of this date, your coverage is no longer active.

How to Reinstate Your Policy:

You have the right to reinstate your coverage if we receive the past-due premium amount of $[Amount] by [Grace Period End Date]. If payment is received by this date, your coverage will be restored without a gap in protection.

Reinstatement Due to Cognitive Impairment or Functional Incapacity:

In accordance with state regulations, you may be eligible for a longer reinstatement period of up to five (5) months if the lapse was due to cognitive impairment or functional incapacity. If you or your representative believe this applies to your situation, please contact us immediately to provide the necessary medical demonstration.

Action Required:

- To keep your policy, please send a check for $[Amount] to the address listed above.
- Alternatively, you may pay by phone at [Phone Number] or via our website at [Website URL].

If you have already mailed your payment, please disregard this notice. If you have questions regarding your benefits or this notice, please call our Customer Service Department at [Phone Number].

Sincerely,

[Sender Name/Department]
[Company Name]