

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

Date: [Current Date]

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

RE: NOTICE OF POLICY LAPSE DUE TO INSUFFICIENT FUNDS

Policy Number: [Policy Number]
Payment Due Date: [Due Date]
Amount Due: \$[Amount]

Dear [Policyholder Name],

We are writing to inform you that your recent health insurance premium payment was returned by your financial institution due to **Insufficient Funds (NSF)**.

As a result, your health insurance coverage is currently in a **Grace Period**. If the outstanding balance is not paid in full by [Final Deadline Date], your coverage will be terminated effective [Termination Date].

Action Required:

- Please submit a payment of \$[Amount] plus a returned item fee of \$[Fee Amount] immediately.
- Payments can be made via our online portal, by phone, or by mailing a certified check or money order.

A lapse in coverage may result in the denial of medical claims and could affect your eligibility for future enrollment. If you have already sent a replacement payment, please disregard this notice.

If you believe this notice was sent in error or if you have questions, please contact our Customer Service department at [Phone Number].

Sincerely,

[Name/Department]
[Insurance Company Name]