

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

[Date]

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

RE: NOTICE OF POLICY LAPSE  
Policy Number: [Policy Number]  
Policy Type: [Type of Insurance]

Dear [Policyholder Name],

This letter is to inform you that your payment for the policy listed above was returned by your financial institution due to Insufficient Funds (NSF).

As a result, your premium payment has not been honored. Because the required premium was not received by the due date, your insurance coverage has **LAPSED** effective [Cancellation Date/Time].

There is currently no insurance coverage in force for this policy. Any claims occurring after the lapse date will not be covered.

To request reinstatement of your coverage, you must provide the following immediately:

- A replacement payment in the amount of \$[Amount Due].
- An NSF processing fee of \$[Fee Amount].
- A signed Statement of No Loss (if required).

Please note that reinstatement is subject to company approval and is not guaranteed. Payment must be made by certified funds (Cashier's Check, Money Order, or Cash) at our office.

If you have already sent a replacement payment, please contact our office immediately at [Phone Number] to confirm receipt.

Sincerely,

[Agent/Representative Name]  
[Agency Name]