[Company Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Conditional Offer for Reinstatement of Health Care Coverage
Member ID: [Member ID Number]
Policy Number: [Policy Number]

Dear [Member Name],

Our records indicate that your health care coverage lapsed on [Date of Lapse] due to non-payment of premiums. As a result, your benefits and claims coverage are currently inactive.

We are pleased to offer you a conditional opportunity to reinstate your coverage without a gap in service. To qualify for reinstatement, you must meet the following requirements by **[Due Date/Deadline]**:

- **Full Payment:** Submit a total payment of $[Total Amount Owed]. This includes all past-due premiums and the current month's premium.
- **Reinstatement Form:** Complete, sign, and return the enclosed "Application for Reinstatement."
- **Evidence of Insurability:** [Include this section only if applicable: Provide the requested medical history documentation as outlined in the attached form.]

Important Conditions:

Please be advised that this offer is conditional. Coverage is not guaranteed until we have received your payment in full and approved your application. If your payment is returned for insufficient funds or if the required documentation is incomplete, your policy will remain terminated.

If we do not receive the total payment and required documents by [Due Date/Deadline], this offer will expire, and you may be required to wait until the next Open Enrollment period to apply for new coverage.

You may submit your payment via [Payment Methods: Online Portal/Phone/Mail].

If you have already sent your payment or believe this letter was sent in error, please contact our Member Services Department at [Phone Number] immediately.

Sincerely,

[Sender Name/Department]
[Company Name]

Enclosures: [Application for Reinstatement, Return Envelope]