

Date: [Insert Date]

Policyholder Name: [Insert Name]

Address: [Insert Address]

City, State, Zip: [Insert City, State, Zip]

Policy Number: [Insert Policy Number]

Lapse Date: [Insert Date of Lapse]

Subject: FINAL OPPORTUNITY TO REINSTATE YOUR POLICY

Dear [Insert Name],

Our records indicate that your insurance policy has lapsed due to non-payment of premiums. We are writing to provide you with one final opportunity to reinstate your coverage without the requirement of a new application or a medical exam.

To restore your benefits and maintain your current coverage rates, we must receive the following no later than [Insert Deadline Date]:

- Payment of the past-due amount: \$[Insert Amount]
- A signed copy of the enclosed Reinstatement Request form.

Why this matters:

If you do not reinstate your policy by the deadline, your coverage will remain terminated. Any future application for coverage may be subject to higher premiums based on your current age or changes in your health status.

Please submit your payment via [Insert Payment Method - e.g., online portal, phone, or enclosed envelope].

If you have already sent your payment, please disregard this notice. If you have questions regarding your policy or the reinstatement process, please contact our Customer Service Department at [Insert Phone Number].

Sincerely,

[Insert Name/Department]

[Insert Company Name]