

[Company Name]  
[Department Name]  
[Company Address]  
[City, State, Zip Code]

[Date]

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

**Subject: NOTICE OF REINSTATEMENT OPTION - Policy Number: [Policy Number]**

Dear [Policyholder Name],

Records indicate that your life insurance policy lapsed on [Lapse Date] because the cash value was insufficient to cover the required monthly insurance charges and fees.

We value your protection and are pleased to inform you that you have the option to reinstate your coverage. Reinstating your policy allows you to maintain your original underwriting benefits without the need to apply for a brand-new policy.

**Requirements for Reinstatement:**

- **Reinstatement Application:** Please complete, sign, and return the enclosed "Application for Reinstatement" form.
- **Evidence of Insurability:** Depending on the time elapsed since the lapse, we may require updated health information.
- **Required Payment:** To restore your policy and provide sufficient cash value for future charges, a minimum payment of \$[Amount] is required.

**Deadline for Submission:**

To take advantage of this reinstatement option, all requirements and payments must be received by [Deadline Date].

Once we receive your application and payment, our underwriting department will review the request. You will be notified in writing once the reinstatement is officially approved and your coverage is active again.

If you have any questions regarding your policy or the reinstatement process, please contact our Customer Service Department at [Phone Number] or [Email Address].

Sincerely,

[Signature]  
[Sender Name]  
[Title]

Enclosure: Reinstatement Application Form