FINAL NOTICE: HEALTH INSURANCE LAPSE AND REINSTATEMENT OPPORTUNITY

Date: [Insert Date]

Recipient Name: [Insert Name]
Policy Number: [Insert Policy Number]
Address: [Insert Address]

Dear [Insert Name],

This is a formal notification that your health insurance coverage has lapsed effective [Insert Date] due to non-payment of premiums. As of this date, you no longer have active health insurance coverage under this policy.

Current Amount Due: $[Insert Amount]

We are offering a final opportunity to reinstate your coverage without a gap in service or the requirement for a new application. To reinstate your policy, you must complete the following steps by [Insert Deadline Date]:

- Submit the full outstanding balance of $[Insert Amount].
- Complete and sign the attached Reinstatement Request Form.
- [Optional] Provide a Statement of Good Health if required.

If payment is not received by [Insert Deadline Date], your policy will be permanently terminated. After that date, you may be required to wait until the next Open Enrollment period or undergo a new underwriting process to obtain coverage.

Please contact our Billing Department at [Insert Phone Number] or visit [Insert Website] to make a payment immediately.

Sincerely,

[Insert Name/Department]
[Insert Company Name]