

[Date]

[Policyholder Name]

[Address]

[City, State, Zip Code]

## **Subject: Notice of Policy Lapse and Reinstatement Option**

Dear [Policyholder Name],

We are writing to inform you that your dental insurance policy, [Policy Number], has lapsed effective [Lapse Date] due to non-payment of premiums.

As a result, your dental coverage is no longer active, and any claims for services provided after this date will not be covered.

### **Option to Reinstatement Your Policy**

We value your membership and would like to offer you the opportunity to reinstate your coverage without a gap in service. To reinstate your policy, please complete the following steps by [Deadline Date]:

- Pay the outstanding balance of \$[Amount Due].
- Pay the upcoming premium of \$[Amount].
- [Optional: Complete the enclosed reinstatement application].

If we receive your payment and required documentation by [Deadline Date], your coverage will be restored to active status effective immediately.

### **How to Make a Payment**

You can make a payment through any of the following methods:

- **Online:** [Website URL]
- **Phone:** [Phone Number]
- **Mail:** Send a check to [Payment Address]

If you have already sent your payment, please disregard this notice. If you have any questions regarding your account, please contact our customer service department at [Phone Number] or [Email Address].

Sincerely,

[Sender Name/Department]

[Insurance Company Name]