URGENT: NOTICE OF HEALTH INSURANCE TERMINATION

Date: [Insert Date]

Policy Number: [Insert Policy Number]
Insured Name: [Insert Name]

Dear [Insert Name],

This is an urgent notification regarding your health insurance coverage. Our records indicate that we have not received the premium payment due on [Insert Due Date].

Your policy is currently in a grace period. If payment is not received by [Insert Final Termination Date], your health insurance coverage will lapse and your policy will be terminated effective [Insert Effective Date].

Payment Details:

- Past Due Amount: $[Insert Amount]
- Current Premium: $[Insert Amount]
- **Total Amount Due: $[Insert Total Amount]**

To avoid a gap in coverage and loss of benefits, please make a payment immediately using one of the following methods:

- Online: [Insert Website URL]
- Phone: [Insert Phone Number]
- Mail: [Insert Mailing Address]

If you have already sent your payment, please disregard this notice. If you are experiencing financial hardship or have questions regarding your bill, contact our customer service department at [Insert Phone Number] immediately.

Sincerely,

[Insert Company Name]
Billing Department