

[Your Name/Company Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

Subject: Notice of Policy Lapse and Reinstatement Requirements

Policy Number: [Insert Policy Number]
Policy Type: [Insert Type, e.g., Life, Health, Auto]

Dear [Recipient Name],

This letter is to inform you that your insurance policy has lapsed effective [Date] due to non-payment of the premium scheduled for [Original Due Date].

We value you as a policyholder and would like to help you restore your coverage. To reinstate your policy without a gap in protection, please complete the following steps by [Deadline Date]:

- Pay the overdue premium amount of: \$[Amount]
- Pay the late fee (if applicable) of: \$[Amount]
- Submit the enclosed Reinstatement Application/Statement of Good Health.

Total Amount Due for Reinstatement: \$[Total Amount]

Please note that coverage is not active until your payment is processed and your reinstatement application is approved. If we do not receive the requirements listed above by the deadline, you may be required to apply for a new policy at current market rates.

You can make your payment via [Payment Method: Online Portal/Phone/Mail].

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].

Sincerely,

[Your Name/Signature]
[Title/Department]