

Date: [Insert Date]

Policyholder Name: [Insert Name]

Policy Number: [Insert Policy Number]

Subject: Denial of Conditional Policy Reinstatement Agreement

Dear [Insert Policyholder Name],

We are writing to formally notify you that your request for a Conditional Policy Reinstatement Agreement regarding the above-referenced policy has been denied.

After a thorough review of your application and policy history, we are unable to proceed with reinstatement due to the following reason(s):

- [Insert Reason 1, e.g., Failure to submit required payment by the deadline]
- [Insert Reason 2, e.g., Incomplete medical evidence or underwriting requirements]
- [Insert Reason 3, e.g., History of multiple lapses]

As a result, your policy remains lapsed and inactive as of [Insert Lapse Date]. No coverage is currently in effect, and we are unable to accept any further premium payments for this specific policy.

If you believe this decision was made in error or if you have additional documentation that was not previously considered, you may submit a written appeal to our Review Department at [Insert Address/Email] within [Insert Number] days of the date of this letter.

If you are interested in obtaining new coverage, you may apply for a new policy, which will be subject to current underwriting guidelines and premium rates.

For questions regarding this notice, please contact our Customer Service Department at [Insert Phone Number].

Sincerely,

[Insert Name/Department]

[Insert Company Name]