

**Date:** [Insert Date]

[Policyholder Name]

[Address Line 1]

[Address Line 2]

[City, State, Zip Code]

**Subject: Notice of Lapsed Policy and Conditional Reinstatement Offer**

**Policy Number:** [Insert Policy Number]

**Expiration/Lapse Date:** [Insert Date]

Dear [Policyholder Name],

Our records indicate that we have not received the premium payment required to keep your policy active. Consequently, your coverage lapsed effective [Insert Date] due to non-payment.

We value your business and would like to offer you the opportunity for **Conditional Reinstatement** of your policy. To restore your coverage without a gap, you must satisfy the following requirements by [Insert Deadline Date]:

- Submit the past-due premium amount of: \$[Insert Amount]
- Pay the late reinstatement fee of: \$[Insert Fee Amount]
- Complete and sign the enclosed Statement of Good Health / Reinstatement Application.

**Important Conditions:**

Please be advised that this reinstatement is "conditional." Coverage is not guaranteed until we have received your payment and reviewed your application. If your application is declined, your payment will be refunded in full, and the policy will remain lapsed. Any claims occurring during the period the policy was lapsed may not be covered.

To make a payment immediately, please visit [Insert Website URL] or call our billing department at [Insert Phone Number].

If you have already sent your payment, please disregard this notice.

Sincerely,

[Sender Name/Department]

[Company Name]

[Contact Information]