

**Date:** [Insert Date]

**Policyholder Name:** [Insert Name]

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

**Expiration Date:** [Insert Date of Expiration]

# Post-Expiration Policy Reinstatement Agreement

Dear [Insert Policyholder Name],

This document serves as a formal agreement regarding the reinstatement of your insurance policy, which expired on [Insert Date] due to [Insert Reason, e.g., non-payment].

By signing this agreement, you acknowledge and agree to the following terms:

- **No Loss Provision:** You certify that no losses, accidents, or claims have occurred between the expiration date and the time of signing this agreement.
- **Payment Requirements:** Reinstatement is contingent upon the receipt of [Insert Amount] representing past due premiums and applicable late fees.
- **Continuous Coverage:** Upon approval and receipt of payment, coverage will be reinstated effective [Insert Reinstatement Date/Time].
- **Terms and Conditions:** All original terms, conditions, and exclusions of the policy remain in effect.

Please sign and return this letter by [Insert Deadline Date] to finalize the reinstatement process.

**Policyholder Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Company Representative Signature:** \_\_\_\_\_

**Title:** [Insert Title]

**Date:** \_\_\_\_\_