FINAL NOTICE: URGENT ACTION REQUIRED

Date: [Insert Date]

Recipient Name: [Insert Member Name]
Policy Number: [Insert Policy Number]
Expiration Date: [Insert Date of Expiration]

Dear [Insert Member Name],

This is the final notice regarding your health insurance coverage. Our records indicate that your current policy is scheduled to expire on **[Insert Expiration Date]**.

If your policy expires, you will lose access to your healthcare benefits, including coverage for doctor visits, prescriptions, and emergency services. To prevent a lapse in coverage, you must take action immediately.

To renew your policy or discuss your options:

- Call our Member Services department at: [Insert Phone Number]
- Log in to your online portal at: [Insert Website URL]
- Visit our local office at: [Insert Address]

If you have already sent your renewal payment or submitted your application, please disregard this notice.

Sincerely,

[Insert Name/Department]
[Insert Insurance Company Name]