<Date>
<Case Number>

<HOH Name>
<Mailing Address>
<City>, IA <Zip>

This letter is to inform you that since you didn't pay your monthly premium, Hawki dental benefits will end for the following child(ren) on <Date>.

ID Number	Member Name
<0000000X>	<MEMBER NAME>
<0000000X>	<MEMBER NAME>
<0000000X>	<MEMBER NAME>
<0000000X>	<MEMBER NAME>
<0000000X>	<MEMBER NAME>

You must pay your past due balance before the date listed above to remain enrolled in the Hawki program. Your dentist visits will not be paid for until you do this. Call Hawki Member Services at **1-800-257-8563** to find out how much you owe.