[Your Name/Company Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Coordination of Benefits - Overlapping Coverage Notice

Policyholder Name: [Name of Insured]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number (if applicable): [Claim Number]

To Whom It May Concern,

I am writing to formally notify you of overlapping commercial insurance coverage regarding the policy mentioned above. This letter serves as a request for the Coordination of Benefits (COB) between your company and the secondary carrier listed below.

Secondary Insurance Information:
Carrier Name: [Secondary Insurance Company]
Policy Number: [Secondary Policy Number]
Effective Date: [Start Date]

Based on the "Order of Benefit Determination Rules," it appears that [Your Company Name/Carrier Name] should be designated as the [Primary/Secondary] payer for the following reasons: [Reason, e.g., Birthday Rule, Active vs. Inactive status, or Specific Contract Language].

Please update your records to reflect this coordination. If any claims have been overpaid or underpaid due to this overlap, please provide an Explanation of Benefits (EOB) and instructions for the reconciliation of funds.

Enclosed are copies of the declarations pages for both policies for your review.

Should you require additional information, please contact me at [Phone Number]. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Position]