[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Coordination of Benefits Update

Member Name: [Name of Policy Holder]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to update the Coordination of Benefits (COB) information for my account. Please update your records to show that [Insurance Company Name] is my primary insurance provider.

The following individuals are covered under this policy:
[List Full Names of Dependents]

Regarding other coverage (Check one):
[ ] I/We have no other health insurance coverage.
[ ] I/We have secondary coverage through the following carrier:

Secondary Insurance Company: [Company Name]
Secondary Policy ID: [Policy ID]
Secondary Policy Holder: [Name]

Please update my file immediately to ensure that all pending and future claims are processed without delay. If you require further information, please contact me at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]