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

[Date]

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

RE: Coordination of Benefits Request

Policyholder Name: [Your Name or Primary Insured Name]
Policy Number: [Your Policy Number]
Group Number: [Your Group Number]

To Whom It May Concern,

I am writing to formally request a coordination of benefits (COB) for my account. I am currently covered under two health insurance plans and would like to ensure that my claims are processed correctly between the primary and secondary payers.

Below is the information for both insurance policies:

Primary Coverage:
Insurance Company: [Primary Company Name]
Policy Number: [Primary Policy Number]
Group Number: [Primary Group Number]
Policyholder Name: [Primary Policyholder Name]

Secondary Coverage:
Insurance Company: [Secondary Company Name]
Policy Number: [Secondary Policy Number]
Group Number: [Secondary Group Number]
Policyholder Name: [Secondary Policyholder Name]

Please update my file to reflect this dual coverage. If there are specific COB forms required by your office, please send them to my address listed above or provide a link to the digital versions.

Thank you for your assistance in this matter. Please contact me if you require any further information.

Sincerely,

[Your Signature]

[Your Printed Name]