[Insurance Company Name]
[Member Services Department]
[Address Line 1]
[City, State, Zip Code]

[Date]

Subject: Annual Coordination of Benefits (COB) Update Request

Dear [Member Name],

We are writing to request an update regarding your health insurance coverage. To ensure your claims are processed accurately and timely, we must maintain current information regarding any other health insurance coverage you or your dependents may have.

Member Information:
Member Name: [Member Name]
Member ID Number: [ID Number]
Group Number: [Group Number]

Please indicate below if you or any covered dependents are enrolled in another health insurance plan, including Medicare, Medicaid, or a plan through an employer:

[ ] **No**, I/we do not have any other health insurance coverage.
[ ] **Yes**, I/we have other health insurance coverage (Please provide details below).

Other Insurance Details (if applicable):
Name of Policy Holder: _____
Insurance Company Name: _____
Policy/ID Number: _____
Effective Date: _____
Type of Coverage (e.g., Medical, Dental, Vision): _____

Please sign and return this letter in the enclosed envelope or update your information through our member portal at [Website URL] by [Due Date]. Failure to provide this information may result in a delay or denial of your claims.

If you have any questions, please contact our Customer Service department at [Phone Number].

Sincerely,

[Sender Name/Department]
[Insurance Company Name]

Member Signature: _____
Date: _____