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

[Benefits Department Name]
[Company Name]
[Address]
[City, State, Zip Code]

Subject: Spousal Coverage Coordination of Benefits (COB) Verification

To Whom It May Concern,

I am writing to provide the requested information regarding healthcare coverage for my spouse, [Spouse's Full Name], to ensure the proper Coordination of Benefits (COB) between insurance plans.

Please find the insurance status of my spouse below:

Spouse Employment Status:
[ ] Employed (Full-Time/Part-Time)
[ ] Unemployed / Retired
[ ] Self-Employed

Spouse Insurance Information:
[ ] My spouse is enrolled in their employer-sponsored health plan.
[ ] My spouse is NOT enrolled in their employer-sponsored health plan.
[ ] My spouse does not have access to employer-sponsored health coverage.

Secondary Insurance Details (if applicable):
Insurance Carrier: [Insurance Company Name]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Coverage Type: [Medical / Dental / Vision]

I certify that the information provided above is true and accurate to the best of my knowledge. I understand that I must notify the benefits department of any changes to my spouse's insurance status within 30 days of such change.

If you require additional documentation or have further questions, please contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Signature]
[Your Printed Name]