[Parent/Guardian Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

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

RE: Coordination of Benefits (COB) Update

Member Name: [Primary Policy Holder Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Dependent Name: [Child's Name]
Dependent Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

I am writing to provide updated Coordination of Benefits (COB) information for my dependent, [Child's Name]. This information is intended to ensure the accurate processing of medical claims.

Please update your records to reflect that [Child's Name] is covered under the following insurance plans:

Primary Insurance:
Carrier Name: [Carrier Name]
Policy Holder: [Name]
Policy/ID Number: [ID Number]
Effective Date: [Date]

Secondary Insurance:
Carrier Name: [Carrier Name]
Policy Holder: [Name]
Policy/ID Number: [ID Number]
Effective Date: [Date]

According to the "Birthday Rule," the primary coverage should be provided by the parent whose birthday falls earlier in the calendar year. [Explain which parent has the earlier birthday here].

Attached are copies of the front and back of the insurance cards for both plans. Please update your system and reprocess any pending claims that may have been denied due to missing COB information.

If you require any additional information, please contact me at [Phone Number].

Sincerely,

[Signature]
[Printed Name]