Help us keep your child(ren) insured. Complete the following information and return this form to us in the enclosed pre-paid envelope.

I want continued coverage for my child or children through Medicaid. Please begin that		
coverage:		
☐ January 1, 2014, when Medicaid support for their current coverage will end.		
Child's First and Last Name	Medicaid ID #:	Date of Birth:
Your name:	Date:	<u></u>
Signature:	Phone #:	
Mailing Address:	City, State, Zip:	
Medicaid ID #:		
If you have any questions about these changes, please contact Cindy Brock at (208) 364-1983 or by email at brockc@dhw.idaho.gov		