



Intended Termination Date Needed On Individual Application

Please remember that applicants must include an **intended** termination date of any current coverage when applying on the Idaho Individual Application. Terms in this section such as “to current” or “pending” will result in a declined application. There is no risk that the member’s current coverage will be terminated if they do not elect coverage with us as we do not communicate with other carriers regarding the issuance of individual policies.

SECTION 4 - CURRENT/PRIOR COVERAGE (For proper crediting of preexisting condition waiting periods AND Coordination of Benefits, please complete the section below.) Use extra paper if necessary.

If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a *Certificate of Creditable Coverage* from your prior insurance carrier or other appropriate documents to establish prior creditable coverage. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the insurance carrier can determine whose coverage is primary (please use additional paper if needed).

To reduce the 12-month exclusion period by your creditable coverage, you should give your new insurance carrier a copy of any *Certificates of Creditable Coverage* you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage. Please contact your new insurance carrier if you need help demonstrating creditable coverage.

If you have cancelled state of Idaho individual High Risk Pool mandated plan coverage within the past 12 months, you may not be eligible for coverage unless you are a federally defined eligible individual. Please read the *Notice of Federal Eligibility* on the bottom of page 3 of this application.

Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yyyy)	Coverage End Date (mm/dd/yyyy)	Type of Coverage	Will this coverage continue?
			(mm/dd/yyyy)	(mm/dd/yyyy)	<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
			(mm/dd/yyyy)	(mm/dd/yyyy)	<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
			(mm/dd/yyyy)	(mm/dd/yyyy)	<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
			(mm/dd/yyyy)	(mm/dd/yyyy)	<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
			(mm/dd/yyyy)	(mm/dd/yyyy)	<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
			(mm/dd/yyyy)	(mm/dd/yyyy)	<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No

List applicants eligible for coverage under any other plan (group, Medicare, Medicaid, etc.) and type of plan eligibility: