DISENROLLMENT REQUEST FORM

Last Name: _____ **First Name:**_____ **Middle Initial:**___ **Mr. Mrs. Miss Ms.**

Medicare Number: _____

Birth Date: _____ **Sex: M F** **Home Phone Number: (____)** _____ **-** _____

Date Received by EmblemHealth: _____

Please carefully read and complete the following information before signing and dating this disenrollment form:

On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership in my EmblemHealth plan. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

Your signature*: _____ Date: _____

* Or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this disenrollment and 2) documentation of this authority is available upon request by EmblemHealth or by Medicare. (Please submit this documentation with the form).

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____