



## Medicare Disenrollment Form

- If you request disenrollment, you must continue to get all medical care from MVP Health Care until the effective date of disenrollment.
- We will notify you of your effective date of disenrollment once we get this form from you.

Last Name	First Name	Middle Init.	Telephone Number (    )
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Medicare # □□□-□□-□□□□ □	

**Please carefully read and complete the following information before signing and dating this disenrollment form:**  
 If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in MVP Health Care on the effective date of that new enrollment. 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 want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

**Your Signature\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that:

- this person is authorized under State law to complete this disenrollment, and
- documentation of this authority is available upon request by MVP Health Care or by Medicare.

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

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Relationship to Enrollee \_\_\_\_\_

<b>For Plan Use Only</b>	Member ID number: A _____ or 800 _____				
Enter in: <input type="checkbox"/> Amisys <input type="checkbox"/> Facets	Group Name	Group #	Disenrollment Date	Input Date	Initials
ICEP/IEP <input type="checkbox"/> OEP <input type="checkbox"/> AEP <input type="checkbox"/> SEP <input type="checkbox"/> (type): _____					