

Medicare disenrollment form

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

Member information		
Last name	First name	Middle initial
Date of birth (MM/DD/YYYY) ____ / ____ / _____	Best phone number ()	Priority Health Subscriber ID _____ - ____

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period. Your disenrollment effective date will be the last day of the month in which the form is received based on your eligibility for the Election Period.

Choose one of the following:

- ☐ I recently had a change in or lost my extra help paying for Medicare prescription drug coverage on ____ / ____ / ____.
- ☐ I recently started, lost, or had a change in my state Medicaid coverage on ____ / ____ / ____.
- ☐ I am joining employer or union coverage on ____ / ____ / ____.
- ☐ I am enrolled in or will be enrolling in other creditable drug coverage such as TRICARE or VA coverage.
- ☐ I am joining a Medigap plan on ____ / ____ / ____.
- ☐ I am joining a PACE program on ____ / ____ / ____.
- ☐ Less than 12 months ago I joined this plan when I turned 65. I want to switch to Original Medicare and I'm joining a Drug Plan.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care facility. I moved/will move on ____ / ____ / ____.
- ☐ I elect to disenroll during the Annual Enrollment Period and I will be disenrolled effective January 1 of the upcoming plan year. *(Available October 15th – December 7th).*
- ☐ I elect to disenroll during the Medicare Advantage Open Enrollment Period and return to Original Medicare. *(Available January 1st – March 31st or by the end of the 3rd month following my Part A and Part B entitlement).*

If none of these statements apply to you or you're not sure if you are eligible to disenroll, please contact Priority Health Medicare. By phone, call toll-free at 888.389.6648 (TTY 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. You can also log in to your member account at ***priorityhealth.com*** to send us a message.

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in this Priority Health Medicare plan on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. Additionally, I understand that by disenrolling from this plan without replacing Medicare prescription drug coverage in the future, I may have to pay a higher premium for Medicare drug coverage.

Signature	
Member signature X _____	Today's date ____ / ____ / ____

A paper form can only be accepted with a handwritten signature. Electronic, digital or typed signatures are not permitted per the Centers for Medicare and Medicaid services.

If you are the authorized representative, please sign above and provide the following information			
Last name	First name	Best phone number ()	
Street address			Unit/Apt/Lot no.
City		State	ZIP code
Relationship to member: ☐ Power of attorney ☐ Legal guardian ☐ Conservator			

You may submit this authorized representative documentation by either scan and email or mail legal documents to: Priority Health, MS 1115 1231 E. Beltline, Grand Rapids, MI 49525 or email ***MedicareCS@priorityhealth.com***. You may also create a member account and send the documentation via secure message.

How to submit this completed form:		
Secure Message via Member Portal: member.priorityhealth.com/login/	US mail or in person: Priority Health MS 1175 1231 East Beltline Ave NE Grand Rapids, MI 49525	Fax: 616.942.7204