Mediare disenrollment form

Priority Health

Priority Health Medicare Advantage plans — PPO, HMO-POS, and D-SNP

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	Best phone number to reach you	Priority Health Subscriber ID
___ ___ / ___ ___ / ___ ___ ___ ___	( )	__ __ __ __ __ __ __ __ __ - 00

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.

Choose one of the following:

- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get extra help paying for my Medicare prescription drug coverage, but I haven't had a change. *(Available January 1st – September 30th).*
- ☐ 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 users call 711). We're available from 8 a.m. to 8 p.m., seven days a week. Or visit ***prioritymedicare.com*** and select Contact Us.

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. 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.

continued>

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

We require documentation to verify legal guardianship agreements. Please scan and email or mail legal documents to:
MedicareCS@priorityhealth.com — or — Priority Health, MS 1115, 1231 E Beltline Ave NE Grand Rapids, MI 49525

How to submit this completed form		
Scan and email *(preferred)*: **PH-MedicareEnrollment@priorityhealth.com**	Mail: **Priority Health MS 1175** **1231 East Beltline Ave NE** **Grand Rapids, MI 49525**	Fax: **616.942.7204**