



**Kaiser Permanente Senior/Medicare Advantage (HMO) or  
Kaiser Permanente Senior/Medicare Advantage  
Medicare Medi-Cal/Medicaid (HMO D-SNP) Plan**

**DISENROLLMENT FORM**

Each individual requesting disenrollment will need to complete their own form. If you have any questions, please call Kaiser Permanente at the phone number listed below for your region, seven days a week, 8 a.m. to 8 p.m.

<b>California</b>	<b>1-800-443-0815 (TTY 711)</b>	<b>Colorado</b>	<b>1-800-476-2167 (TTY 711)</b>
<b>Georgia</b>	<b>1-800-232-4404 (TTY 711)</b>	<b>Hawaii</b>	<b>1-800-805-2739 (TTY 711)</b>
<b>Mid-Atlantic States</b>	<b>1-888-777-5536 (TTY 711)</b>	<b>Northwest</b>	<b>1-877-221-8221 (TTY 711)</b>

If you request disenrollment, you **must** continue to get all medical care from Kaiser Permanente or a Kaiser Permanente network provider, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment **before** you seek medical services outside of Kaiser Permanente’s network. We will notify you of your effective date of disenrollment after we get this form from you.

**PLEASE TYPE OR PRINT USING BLACK OR BLUE INK**

Please indicate which Kaiser Permanente region you wish to disenroll from:

CALIFORNIA  COLORADO  GEORGIA  HAWAII  MID-ATLANTIC STATES  NORTHWEST

KAISER PERMANENTE MEDICAL/ HEALTH RECORD #	LAST NAME	FIRST NAME	MI
	MAILING ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE		HOME PHONE NUMBER	

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside this period. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.

## PLEASE SELECT A DISENROLLMENT REASON BELOW

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.

- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) \_\_\_\_\_.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_.
- I am joining a PACE program on (insert date) \_\_\_\_\_.
- I am joining employer or union coverage on (insert date) \_\_\_\_\_. I am requesting a disenrollment date of (insert date) \_\_\_\_\_ with the understanding that this must be approved by CMS.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) \_\_\_\_\_.
- I have moved out of the Kaiser Permanente service area on (insert date) \_\_\_\_\_. I am requesting a disenrollment date of \_\_\_\_\_ with the understanding that this must be approved by CMS.
- I have joined another plan with creditable prescription drug coverage (coverage as good as Medicare's) on (insert date) \_\_\_\_\_.
- My employer group coverage has ended or will transfer to a new health care plan on (insert date) \_\_\_\_\_. I am requesting a disenrollment date of \_\_\_\_\_ with the understanding that this must be approved by CMS.
- I was affected by an emergency or a major disaster as declared by a Federal, state, or local government entity. One of the other statements here or another election period applied to me, but I was unable to make my disenrollment request because of the disaster. Insert what emergency or major disaster and the date \_\_\_\_\_.
- Other – Please explain \_\_\_\_\_.

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

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente 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.

**For Employer Group/Trust Fund members only:** I understand that my disenrollment from Kaiser Permanente Senior/Medicare Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

**For Federal Employees Health Benefit (FEHB) Program members only:** The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Senior/Medicare Advantage for Federal employees.

**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: (1) this person is authorized under State law to complete this disenrollment; and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

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

Name: _____
Address: _____
Phone Number: _____
Relationship to enrollee: _____

Please contact Kaiser Permanente if you need information in another language or accessible format (Braille).

**Return the signed form to:**

Kaiser Permanente – Medicare Unit  
P.O. Box 232400  
San Diego, CA 92193-2400

