Medicare Prescription Drug Plans

HealthSpring℠

Member ID: _____

This is a form to disenroll from your Medicare plan. Here are a few things to know as you complete the form:

- **You must complete all items, and sign and date the form.**
- Medicare has rules for when you can join or leave a Medicare plan (called enrollment periods). You must have a valid enrollment period to leave the plan.
  Typically, you may disenroll from a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to disenroll from a Medicare prescription drug plan outside of this period.
- If you don't have other prescription drug coverage that's as good as Medicare's (called creditable coverage), you may have to pay a late enrollment penalty if you try to enroll in a plan later.

Last Name:	**First Name:**	**Middle Initial**:
Member ID:		
Birth Date:	**Sex:** □ **M** □ **F**	**Home Phone Number:** **( )**

Please read the following statements carefully and check the box if the statement applies to you.
By checking any of the following boxes you certify that, to the best of your knowledge, you are eligible for an Enrollment 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 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 moving/moved out of the plan service area. I will move/moved on (insert date) _____.

☐ I am joining a PACE program on (insert date) _____.

☐ I am joining employer or union coverage on (insert date) _____.

☐ I have other creditable prescription drug coverage (for example: TRICARE or VA coverage) with (insert name of other coverage) _____.

☐ 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) _____.

We're here to help

Please give us a call if you need help responding to the items on this form. **You can reach us at 1-800-222-6700** 7 days a week, 8am – 8pm, local time. Our automated phone system may answer your call during weekends from April 1 – September 30.

By completing this disenrollment request, **I acknowledge:**

There are limited times in which I will be able to join other Medicare plans, unless I qualify for a special enrollment period. HealthSpring will notify me of my disenrollment date after they confirm I'm eligible to leave the plan. I can submit a disenrollment request by calling 1-800-MEDICARE (1-800-633-4227). They're available 24/7. TTY users should call 877-486-2048. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at my enrolled plan's network pharmacies to get coverage. I understand that I am requesting to disenroll from my Medicare Prescription Drug Plan and, if I don't have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

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 Medicare.

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

Name: _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee _____