

Notice to Send out Disenrollment Form

<DATE>
<FIRST NAME LAST NAME>
<ADDRESS LINE 1>
<ADDRESS LINE 2>

Dear <Name of Member>:

Attached is the disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <plan name>.

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

What is Extra Help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

When should I fill out the disenrollment request form?

- You **should** fill out the attached form if you want to change to Original Medicare only and do not want Medicare prescription drug coverage.
- You **shouldn't** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage plan or other Medicare health plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.

- You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.

Until your disenrollment date, you must keep using <plan name> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <plan name>'s network.

How do I submit the disenrollment request?

If you want Original Medicare, as described above, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at 1-210-766-8854. You can call 1-800-MEDICARE (1-800-633-4227) for information about Medicare plans available in your area. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

What are my Medigap rights?

If you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap policy, also known as Medicare supplemental insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact **Texas State Health Insurance** Assistance Program (SHIP) at 1-800-252-9240. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information about trial periods. TTY users should call 1-877-486-2048.

DISENROLLMENT FORM

If you request disenrollment, you must continue to get all medical care from <plan name> until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of <plan name>'s network. We will notify you of your effective date after we get this form from you.

Last name:	First Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms.
Medicare Number:			
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	

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 <MA plan name> 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: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <plan name> or by Medicare.

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

Name: _____
 Address: _____
 Phone number: _____
 Relationship to Enrollee: _____

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 of this period.

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 get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving 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 joining a PACE program on (insert date) _____.
- I am joining employer or union coverage on (insert date) _____.
- 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) _____.

Please call us at 1-844-282-3026. TTY users should call 711. Member Services is open 8am - 8pm local time, 7 days per week from October 1st – March 31st and 8am-8pm local time Monday –Friday April 1st- September 30th.

Thank you.