KAISER PERMANENTE®

Kaiser Permanente Medicare Health Plan

DISENROLLMENT FORM

Each individual requesting disenrollment will need to complete their own form. If you have any questions, call Kaiser Permanente at the phone number listed below for your region, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

California:	**1-800-443-0815**	**Mid-Atlantic States:**	**1-888-777-5536**
Colorado:	**1-800-476-2167**	**Northwest:**	**1-877-221-8221**
Georgia:	**1-800-232-4404**	**Washington:**	**1-888-901-4600**
Hawaii:	**1-800-805-2739**		

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

PRINT YOUR ANSWERS USING BLACK OR BLUE INK AND FILL IN CHECK BOXES WITH AN X

Please indicate which Kaiser Permanente **region** you reside in:

☐ **CALIFORNIA** ☐ **COLORADO** ☐ **GEORGIA** ☐ **HAWAII** ☐ **MID-ATLANTIC STATES** ☐ **NORTHWEST** ☐ **WASHINGTON**

Kaiser Permanente Medical/Health Record#:

Medicare #:

LAST Name:

FIRST Name:

MI:

Birth Date: (mm/dd/yyyy)

Home Phone Number:

Mobile Phone Number:

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

County:

State:

ZIP Code:

Mailing Address, if different from your permanent address (P.O. Box allowed)

Street Address

City:

County:

State:

ZIP Code:

Email Address:

Typically, you may disenroll from a Medicare Advantage or Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. You may also disenroll from a Medicare Advantage plan 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 or Medicare prescription drug plan outside these periods. If you have questions about when you may disenroll from our Plan, call us at the phone number for your region listed on page 1.

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 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.
- ☐ 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 Medicare Advantage/Senior 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 Benefits (FEHB) Program: Your disenrollment from Medicare Advantage/Senior Advantage will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. However, your disenrollment will impact the additional benefits you receive as a member of Kaiser Permanente Medicare Advantage/Senior Advantage for Federal employees.

For Postal Service Health Benefits (PSHB) Program members: If you are disenrolling from your PSHB Prescription Drug Plan (PDP), or Medicare Advantage with Prescription Drug (MAPD) plan, you will no longer receive any prescription drug coverage under your PSHB plan. Additionally, you may be required to keep your Original Medicare Part B enrollment in order for your PSHB coverage to continue.

I understand that my signature (or the signature of the person authorized to act on my behalf) on this form means that I have read and understand the contents of this form. If signed by an authorized representative (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.

Signature:

Today's Date:

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

Name:

Address:

Phone Number:

Relationship to Member:

Return the signed form to:

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

You can also FAX or EMAIL your completed form to:

FAX: **1-855-355-5334**

EMAIL: **KPMedicareEnrollments@kp.org**