Excellus

P.O. Box 211316
Eagan, MN 55121

For Internal Use

Please fill out and carefully read all information below before signing and dating this disenrollment form.

To terminate your policy, please fax this completed form to 716-857-6160 or mail to the address listed below.

Medicare Enrollment
P.O. Box 211316
Eagan, MN 55121

Last Name: First Name: Middle Initial:		☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Member ID:	Plan Name:	
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )

By completing this disenrollment request, I agree to the following:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Medicare Blue Choice or Medicare Blue PPO 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.

I understand that I am disenrolling from my **Medicare Advantage Plan as of:** _____.

Your Signature*_____ Date: _____

OR

I understand that I am disenrolling from my **Medicare Supplement Plan as of:** _____.

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 Medicare Blue Choice, Medicare Blue PPO, Medicare Supplement Plan or by Medicare.

Requests must be received by the plan prior to the requested termination date. Upon processing of the request, you will receive a confirmation of disenrollment letter which includes your termination date.

If you are the authorized representative, you must provide the following information:
Name: _____
Address: _____
Phone Number: (_____) _____- _____
Relationship to Enrollee:_____

If you request disenrollment, you must continue to get all medical care from Medicare Blue Choice, Medicare Blue PPO, or Medicare Supplement Plan until the effective date of disenrollment.

Contact us to verify your disenrollment before you seek medical services out of Medicare Blue Choice, Medicare Blue PPO, or Medicare Supplement Plan's network.

We will notify you of your effective date after we get this form from you.

Disenrolling from your Medicare Blue Choice, Medicare Blue PPO, or Medicare Supplement Plan does not automatically disenroll you from any stand-alone Medicare plan that you may be currently enrolled in.

If you need additional information you can contact our Customer Service Department at 1-877-883-9577 (TTY: 1-800-662-1220). Our office hours are Monday through Friday, 8:00am to 8:00pm; or if you are calling from October 1-March 31, representatives are available to assist you 7 days a week from 8:00am to 8:00pm.