20 S Clinton Ave
Rochester, NY 14604
www.mvphealthcare.com

Medicare Advantage Disenrollment Form

- If you request disenrollment, you must continue to get all medical care from MVP Health Care until the effective date of disenrollment.
- We will notify you of your effective date after we get this form from you.

Last Name	First Name	Middle Initial	Telephone Number ( )

Gender (circle one) Male / Female	Date of Birth (MM/DD/YYYY) / /	Medicare # _____-_____-_____	MVP Member ID #

Typically, you may disenroll from a Medicare Advantage plan only during the annual election 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 these periods.

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 to disenroll.

¨ I am joining a different Medicare plan during the Annual Election Period (Oct. 15 -Dec. 7).
¨ I am changing to a different Medicare plan or Original Medicare during the Medicare Advantage Open Enrollment Period.
¨ I recently moved outside of the service area for my current plan. I moved on (date): _____
¨ I am joining employer or union coverage on (insert date) _____.
¨ I recently had a change in my Medicaid (started receiving 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 (started receiving 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 my 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 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) _____.

If none of these statements applies to you or you're not sure, please contact the MVP Medicare Customer Care Center at:

1-800-665-7924

TTY users may call 711

Representatives are available to serve you, Monday – Friday, 8 am – 8 pm. From October 1 – March 31, call seven days a week from 8 am to 8pm.

Please Sign on Back

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 MVP Health Care 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 from Medicare.

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

Name : _____

Address: _____

Phone Number: (____) _____- _____

Relationship to Enrollee _____

Return this completed form to:

MVP Health Care
Attn: Medicare Enrollment
20 S Clinton Ave
Rochester, NY 14604