220 Alexander St.
Rochester, NY 14607
**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 Init. | 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 Disenrollment Period from January 1 through February 14 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
☐ 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) _____.

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

**1-800-665-7924**
TTY users may call 1-800-662-1220

Representatives are available to serve you, Monday – Friday, 8 am – 8 pm. From October 1 – February 14, call seven days a week from 8 am to 8 pm.

**Please Sign on Back**

**Please carefully read the following information before signing and dating this disenrollment form:**

I do not need to complete this 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 _____