



If you request disenrollment, you must continue to receive all medical care from Medicare Blue Choicesm until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of the Medicare Blue Choice network. We will notify you of your effective date after we have received 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 #			
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:

On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership in Medicare Blue Choice. 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 do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

Your Signature*: _____ **Date:** _____

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 Excellus BCBS or by Medicare.

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