Medica Advantage Solution® (HMO-POS), (PPO) and Medica Advantage℠ (PPO) Plans

2024 Request for Disenrollment Form

1	PERSONAL INFORMATION		
	Legal First Name	Middle Initial	Last Name
	Gender ❍ Male ❍ Female	Primary Telephone (*With area code)* (____) ____ - _____	Birthdate __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)
	Medica Member Number *(Required)*	Disenrollment Date Requested __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)	
	Note: If you request disenrollment, you must continue to get all medical care from Medica Advantage Solution, or Medica Advantage until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Medica Advantage Solution's, or Medica Advantage's network. We will notify you of your effective date of disenrollment after we get this form.		

2 REASON FOR DISENROLLMENT

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from Oct. 15 – Dec. 7 of each year or during the Medicare Advantage Open Enrollment Period from Jan. 1 – March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the circle if the statement applies to you. By checking any of the following circles 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 __ / __ / __ (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 __ / __ / __ (date).
- ❍ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for 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 __ / __ / __ (date).
- ❍ I am joining a PACE program on __ / __ / __ (date).
- ❍ I am joining employer or union coverage on __ / __ / __ (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 __ / __ / __ (date).
- ❍ I have been affected by a Government entity declared disaster or other emergency.
- ❍ I have an involuntary loss of creditable prescription drug coverage.
- ❍ I am enrolling in or maintaining other creditable drug coverage.
- ❍ I am enrolling in a Chronic Care C-SNP (Chronic Care Special Needs Plan), or I have been declared ineligible for enrollment in a C-SNP.
- ❍ I am eligible for an additional Part D IEP (Initial Enrollment Period).

Note: If none of these statements applies to you or you're not sure, please contact Medica toll free at 1 (866) 269-6804 (TTY: 711) from 8 a.m.-8 p.m. CT, 7 days a week to see if you are eligible to disenroll.

3	SIGN & DATE

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 Medica Advantage Solution or Medica Advantage, 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.

If signed by an authorized representative, 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 Medica or by Medicare.

X _____ ___ / ___ / ___

Your Signature or Authorized Representative Signature — Today's Date

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

Return completed form one of two ways:

Mail	Fax
Medica PO Box 267008 Weston, FL 33326	1 (800) 294-5196

Medica

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