Medica Prime Solution® (Cost) Plan

2022 Request for Disenrollment Form

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your effective date after we get this form from you.

Instead of sending a disenrollment request to Medica you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, to disenroll by telephone. TTY users should call 1 (877) 486-2048.

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)		
	Permanent Resident Address			
	Street			
	City	State	ZIP Code	County

2 WHEN YOU CAN MAKE CHANGES TO YOUR MEDICARE COVERAGE

Typically, you may disenroll from a Medicare prescription drug plan only during the annual election period from Oct. 15 - Dec. 7 of each year. There are exceptions that may allow you to disenroll from a Medicare prescription drug plan outside of this period.

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

What is Extra Help?
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778. You can also apply for Extra Help online at www.SocialSecurity.gov/PrescriptionHelp.

3 REASON FOR DISENROLLMENT

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 (800) 234-8755 (TTY: 711) from 8 a.m.-8 p.m. CT, seven days a week to see if you are eligible to disenroll.

4 SIGN & DATE

DISENROLLMENT RESPONSIBILITIES
Please carefully read and complete the following information before signing and dating this disenrollment form.

Note: If you want to return to Original Medicare (also known as the Medicare fee-for-service program), then you must complete this disenrollment form. We will notify you of the effective date of your disenrollment after we have received this form from you.

If you want to join another Medicare Advantage or Medicare health plan immediately following termination from Medica Prime Solution, then you **do not** need to complete this form. Once you enroll in another Medicare plan, your current membership in Medica Prime Solution will automatically be cancelled. However, please note that you can generally only choose other plans at certain times of the year.

If you have selected to have Medicare prescription drug coverage from Medica, by disenrolling from Medica Prime Solution you are also disenrolling from Medicare prescription drug coverage. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Medica Prime Solution network pharmacies to get coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY: 1 (877) 486-2048.

Disenrollment from Medica Prime Solution will be effective on the first day of the month after the month Medica receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and submit it to Medica on April 30, the last day of the month, your disenrollment will be effective the next day, May 1. If you are requesting a later date, disenrollment cannot take place later than the third month after which you submit a completed disenrollment request to Medica. Therefore, if you submit this form on April 30, the latest disenrollment date possible would be July 1.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this form means that I have read and understand the contents of this form. If signed by an authorized representative (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 Medica or by Medicare.

X _____ ___ / ___ / ___
Applicant 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 740110 Atlanta, GA 30374-0110	1 (855) 250-2166

Medica®

PO Box 9310, Minneapolis, MN 55440-9310

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