Priority Health Medicare Disenrollment form

(Employer HMOPOS, Employer PPO, Employer PDP)

For office use only		
Group name		Group number
Subscriber I.D.	Effective date / /	Election type

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

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Last name	First name		Middle initial
Medicare number				
Phone number ( )		Gender ☐ Male ☐ Female	Birth date (month/date/year) / /	
Reason for disenrollment	☐ Moved out of the area ☐ Transferring to other insurance	☐ Other: ____		

By completing this disenrollment request, I agree to the following:

I understand that by requesting disenrollment in Priority Health Medicare, I must continue to receive all medical care from Priority Health Medicare until the effective date of disenrollment. I will contact Priority Health to verify my disenrollment before I seek medical services outside of Priority Health Medicare's network. Priority Health will notify me of my effective date after they have received this form.

I have enrolled in another Medicare Advantage or Medicare prescription drug plan, and I understand Medicare will automatically cancel my current membership in Priority Health Medicare. I understand that I might not be eligible to enroll in another plan at this time and that there are limited times in which I will be able to join other Medicare plans, unless I qualify for special circumstances. 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.

Subscriber signature*	Date / /
Employer 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 disenollment and 2) documentation of this authority is available upon request by Priority Health Medicare or by Medicare.

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

Last name	First name		Middle initial
Street address			
City	State	ZIP code	
Relationship to subscriber	Phone number ( )		

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