

Dear Member:

Attached is the **Priority**Medicare RxSM (PDP) disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from **Priority**Medicare Rx.

When can I disenroll from PriorityMedicare Rx?

Medicare will only allow you to disenroll at certain times during the year. After we receive your disenrollment form, Priority Health Medicare will let you know if you can disenroll at this time. If you can disenroll, we will also tell you the effective date of your disenrollment.

Until your disenrollment date, you should keep using Priority Health Medicare network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, Priority Health Medicare may not pay for your prescriptions. After your disenrollment date, Priority Health Medicare won't cover your prescription drugs.

When can I make changes to my Medicare coverage?

From October 15 through December 7 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of **Priority**Medicare Rx's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help in paying for your prescription drug costs (see below). If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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 [socialsecurity.gov/prescriptionhelp](https://www.socialsecurity.gov/prescriptionhelp).

continued >

When should I submit a disenrollment request?

You should not fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan. Enrolling in a prescription drug plan or a Medicare Advantage-Prescription Drug Plan will automatically disenroll you from **Priority**Medicare Rx.

You should fill out the attached form only if you no longer want Medicare prescription drug coverage and want to disenroll from this coverage completely.

If you would like to disenroll from **Priority**Medicare Rx, please fill out the form, sign it, and send it back to us in the enclosed envelope. You can also fax a signed and dated form to us at 616 942-7204.

Instead of sending a disenrollment request to Priority Health Medicare you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

By disenrolling from **Priority**Medicare Rx, you are disenrolling from your Medicare prescription drug coverage. You may have to pay a late enrollment penalty in addition to your premium for Medicare Prescription Drug coverage if you join a Medicare Drug Plan in the future. For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call Priority Health Medicare at toll-free 888 389-6648, 8 a.m. – 8 p.m., 7 days a week. TTY users should call 711.

Thank you.

Medicare Enrollment Department

Attachment

Priority Medicare RxSM (PDP) Disenrollment form



For office use only		
Plan name		Group number 10003
Subscriber I.D.	Effective date / /	Election type

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.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	Last name	First name	Middle initial
<input type="checkbox"/> Ms. <input type="checkbox"/> Miss			
Medicare number			
Home phone number ()		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date (month/date/year) / /

Typically, you may disenroll from a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to disenroll from a Medicare prescription drug plan outside of this period.

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 for an Election Period.

- 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) _____.
- I am enrolling in other creditable drug coverage (such as TriCare or VA coverage).

If none of these statements applies to you or you're not sure, please contact Priority Health Medicare at toll-free 888 389-6648 (TTY users should call 711) to see if you are eligible to disenroll. We are open 8 a.m. – 8 p.m., 7 days a week.

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

Priority Health Medicare will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Priority Health Medicare network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare prescription drug plan and, if I don't have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

Your signature*	Date
X	

*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 Priority Health Medicare.

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

Name	
Address	
Relationship to enrollee	Phone number ()