

**SECURE HORIZONS GROUP RETIREE  
 MEDICARE ADVANTAGE (MA) PLAN DISENROLLMENT FORM**

(If your **Medicare Eligible** spouse and/or dependent are disenrolling, they must sign this form also)

If you have already joined or intend to join a new Medicare Managed Care plan or Medicare Advantage plan, you do not have to complete this form.

Date: \_\_\_\_\_

I currently have the Secure Horizons Group Retiree MA Plan through \_\_\_\_\_.  
 (Former Employer/Benefits Administrator)

Please disenroll me from the Secure Horizons Group Retiree MA plan. I understand that written disenrollment requests received by PacifiCare by the end of the month, are effective the first day of the next calendar month.

I understand that until the effective date of disenrollment, I am still considered a Secure Horizons Group Retiree MA plan member and must continue to receive covered services from a PacifiCare contracting provider. Neither PacifiCare nor Medicare will pay for services received from non-contracting medical providers, except for emergency services, out-of-area urgently needed services, and routine travel dialysis (in the United States at a Medicare-certified facility), and covered services for which PacifiCare allows me to self-refer to contracting providers.

\_\_\_\_\_  
 (Member Signature or Responsible Party) \_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Member Signature or Responsible Party) \_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Member Name) (Please Print) \_\_\_\_\_  
 (Medicare Number) \_\_\_\_\_  
 (Secure Horizons ID#)

\_\_\_\_\_  
 (Member Name) (Please Print) \_\_\_\_\_  
 (Medicare Number) \_\_\_\_\_  
 (Secure Horizons ID#)

\_\_\_\_\_  
 (Street Address) \_\_\_\_\_  
 (City/State/ZIP ) \_\_\_\_\_  
 (Telephone Number)

**If Durable Power of Attorney, attach Certificate or other written proof of legal guardianship,**

<b>For Internal Use:</b>			
Date Received: _____	Date Processed: _____	Effective Date: _____	D.E. Initials: _____

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PacifiCare will:

- Send me a letter *acknowledging* the receipt of my Disenrollment Request.
  - Once your disenrollment request has been approved by the Centers for Medicare and Medicaid Services (CMS), you will be sent *written confirmation* of the effective date.
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**Send To PacifiCare/Secure Horizons:**

California/Oregon/Washington  
PacifiCare/Secure Horizons  
Membership Accounting  
P.O. Box 489  
Cypress, CA 90630-9802

Texas/Oklahoma  
PacifiCare/Secure Horizons  
Membership Accounting  
P.O. Box 400046  
San Antonio, TX 78229-1946

Arizona/Nevada/Colorado  
PacifiCare/Secure Horizons  
Membership Accounting  
P.O. Box 52078  
Phoenix, AZ 85072-2078

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If you have any questions or problems, please contact Customer Service, Monday through Friday during the hours 6:00 a.m. – 9:00 p.m. at:

Arizona & Nevada  
800-347-8600  
TDHI: 800-360-1797

California  
800-228-2144  
TDHI: 800-685-9355

Colorado  
800-771-4347  
TDHI: 800-360-1797

Texas & Oklahoma  
800-950-9355  
TDHI: 800-557-7595

Washington & Oregon  
800-533-2743  
TDHI: 800-786-7387