Kaiser Permanente Senior Advantage (HMO), Kaiser Permanente Medicare Cost, or Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan (HMO SNP)

KAISER PERMANENTE®

DISENROLLMENT FORM

Northern California or Southern California Region

Each individual disenrolling will need to complete his/her own form. If you have any questions, please call us toll free at **1-800-443-0815** (TTY **1-800-777-1370** for the hearing/speech impaired), seven days a week, 8 a.m. to 8 p.m.

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente's network. We will notify you of your effective date of disenrollment in writing after we get this form from you.

When enrolled in the Kaiser Permanente Senior Advantage plan, you can only disenroll at certain times during the year unless you meet certain special circumstances. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK			
KAISER PERMANENTE MEDICAL RECORD #	LAST NAME	FIRST NAME	MI
	MAILING ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX: ☐ M ☐ F	HOME PHONE NUMBER	

PLEASE SELECT A DISENROLLMENT REASON BELOW

☐ I have moved out of the Kaiser Permanente service area

☐ I have joined another health plan

☐ My employer group coverage has ended

☐ Other—Please explain _____

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

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, or Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan 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.

For Kaiser Permanente Medicare Cost plan members only: 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.

WHITE—Kaiser Permanente
PINK—Employer group/union/trust fund
YELLOW—Keep for your records

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If you want to join another HMO immediately following termination from Kaiser Permanente Medicare Cost, then you do **not** need to complete this form. Once you enroll in another HMO, your current membership in Kaiser Permanente Medicare Cost will automatically be cancelled. However, please note that you can generally only choose other plans at certain times of the year. I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

Disenrollment from the Kaiser Permanente Medicare Cost plan will be effective on the first day of the month after the month Kaiser Permanente receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and submit it to Kaiser Permanente 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 Kaiser Permanente. Therefore, if you submit this form on April 30, the latest disenrollment date possible would be July 1.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Senior Advantage or Medicare Cost may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Senior Advantage or Medicare Cost for Federal employees.

Your 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 disenrollment; and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

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

Name _____

Address _____

Phone number _____

Relationship to enrollee _____

Kaiser Permanente is a health plan with a Medicare contract.

This information is available in a different format by calling the number listed on the first page.

Return the top, signed white copy to:

Kaiser Permanente—Medicare Unit
P.O. Box 232400
San Diego, CA 92193

If required, send the middle pink copy to your employer group or union/trust fund.
Keep the bottom yellow copy for your records.