my Advocate
MEDICARE ADVANTAGE

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1.877.998.0998
TTY 711

Medicare Advantage

Request for Disenrollment

If you request disenrollment, you will be covered by MyAdvocate Medicare Advantage until the effective date of disenrollment. Contact us to verify your disenrollment. We will notify you of your effective date after we get this form from you.

LAST name	FIRST name		Subscriber number
Street address			
City	State	ZIP code	County
Phone number	Birthdate (mm/dd/yyyy) ___ ___ /___ ___ / ___ ___ ___ ___		Sex: ☐ Male ☐ Female
Requested termination date (mm/dd/yyyy) ___ ___ /___ ___ / ___ ___ ___ ___			

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

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 am disenrolling during the Annual Enrollment Period from Oct. 15 – Dec. 7.
- ☐ I am disenrolling during the Medicare Advantage Open Enrollment Period from Jan. 1 – March 31.
- ☐ I had Medicare prior to now, but I'm now turning 65.
- ☐ This is the first Medicare Advantage plan that I have joined. I am still in the trial period from turning 65 or dropping a Medigap policy to disenroll.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert 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 (insert date) _____ /_____ /_____ .
- ☐ I am leaving a Medicare Advantage plan with drug coverage (MA-PD) because I am enrolling in or maintaining other creditable drug coverage.
- ☐ 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 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 (insert date) _____ /_____ /_____ .

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☐ I was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by federal, my state or my local government). One of the other statements applied to me, but I was unable to make my request because of the disaster.

If none of these statements applies to you or you are not sure, contact MyAdvocate Medicare Advantage at 1-888-298-4650 (TTY 711) to see if you are eligible to disenroll. We are open 7 days a week, 8 a.m. to 8 p.m., from Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., from April 1 – Sept. 30.

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

I understand that I am not disenrolled from the MyAdvocate Medicare Advantage plan until my request is processed and approved by the Centers for Medicare and Medicaid Services (CMS).

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in a MyAdvocate Medicare Advantage 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.

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 MyAdvocate Medicare Advantage or by Medicare.

If you are the authorized representative (i.e. power of attorney, conservator, guardian), you must sign above and provide the following information:

Name _____

Address _____

City _____ State _____ ZIP code _____

Phone (_____) _____

Relationship to enrollee:
☐ Power of Attorney Durable/Financial ☐ Guardian of Estate/Conservator

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Tell us the reason(s) for your disenrollment so that we may use this information to help us continually improve our plans:

- ☐ Premiums are too high
- ☐ I am moving out of the service area
- ☐ My doctor was not part of the Medicare Advantage plan network
- ☐ I received poor service from Security Health Plan
- ☐ Out-of-pocket costs are too high
- ☐ I qualified for Medicaid
- ☐ My agent recommended I switch plans
- ☐ Other

  _____

- ☐ I am enrolling in a different plan (specify plan name) _____

  _____

What could we have done differently to keep your membership in a MyAdvocate Medicare Advantage plan?

Return this form in the enclosed envelope to:
MyAdvocate Medicare Advantage
P.O. Box 8000
Marshfield, WI 54449-8000
or fax to: 715-221-9607

Please retain a copy of this form for your records.

MyAdvocate Medicare Advantage is an HMO-POS plan with a Medicare contract. Enrollment in MyAdvocate Medicare Advantage depends on contract renewal. MyAdvocate Medicare Advantage complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call 1-888-298-4650 (TTY 711) or speak with your healthcare provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-298-4650 (TTY 711) o hable con su proveedor.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-298-4650 (Người khuyết tật 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

If you require materials in large print, please call 1-877-509-4979 (TTY 711).