COMMUNITY FIRST
HEALTH PLANS

DISENROLLMENT FORM

Referenced in section: 10
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

If you request disenrollment, you must continue to receive all medical care from Community First Medicare Advantage Plan until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Community First Medicare Advantage Plan's network. We will notify you of your effective date after we receive this form from you.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.		
Last Name:	First Name:	Middle Initial:
Medicare Number: *(Note: may use "Member Number" instead of "Medicare Number")*		
Birth Date: (mm/dd/yyyy)	Sex: ☐ Male ☐ Female	Home Phone Number: ( )

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

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Community First Medicare Advantage Plan on the effective date of the 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 be required 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 Community First Medicare Advantage Plan or by Medicare.

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

Name : _____

Address: _____

Phone Number: ( ) _____ Relationship to Enrollee: _____

ATTESTATION OF ELIGIBILITY FOR AN ELECTION PERIOD

Referenced in section: 30.4
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

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.

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 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 received Extra Help, had a change in the level of Extra Help, or lost Extra Help) on

(insert date) _____ .

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I have not had a change.

☐ 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) _____ .

If none of these statements applies to you or you are not sure, please contact Community First Medicare Advantage Plan at 210-358-6386 or toll free 1-833-434-2347 (TTY users should call 1-800-390-1175) to see if you are eligible to disenroll. We are open 7 days a week from 8 a.m. to 8 p.m.