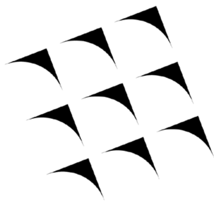

Newport-Mesa
Unified School District

BENEFITS MANAGEMENT
www.nmusd.us/benefits
benefitsmanagement@nmusd.us

Request for Disenrollment

Disenrollment cannot be done retroactively. I understand that this completed and signed form must be provided to NMUSD Benefits Management **at least two (2) weeks prior** to the requested disenrollment date to allow enough time for the processing of disenrollment. **Each individual dis-enrolling must sign this form.**

I am disenrolling from a NMUSD health benefits plan and by signing below I acknowledge:

1. After disenrolling, I have a one-time opportunity to re-enroll in a NMUSD offered medical plan during the next Open Enrollment no later than August 31, 2024, and I am responsible for contacting the Newport Mesa Benefits Management Department at (714) 424-5010 if I want to re-enroll in a medical plan during Open Enrollment no later than August 31, 2024,
2. If I do not reenroll in a NMUSD medical plan prior to August 31, 2024, I will **not** be allowed to reenroll in a NMUSD medical plan in the future, and
3. If my spouse/dependent declines medical they will not be allowed to re-enroll at any time.

Name	______________	Medical ID #:	______________
Name:	______________	Medical ID #:	______________
Address:	______________	Phone:	______________
	______________	NMUSD ID #:	______________

MEDICAL I wish to dis-enroll from:

- ☐ Cigna OAP Medicare Expand
- ☐ Kaiser Senior Advatage
- ☐ SCAN Basic
- ☐ SCAN Enhanced

Name of new Medical Plan: ______________

Effective Date of new Plan: ______________

Reason for Disenrollment: ______________

It is further understood that by dis-enrolling from a Newport-Mesa USD Medical Benefit Plan, and not enrolling in another Medicare Advantage plan with prescription drug coverage or a Medicare prescription drug plan, or if I don't have Creditable Coverage as good as Medicare prescription drug coverage, I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

DENTAL I wish to:

- ☐ Continue my current coverage
- ☐ Continue my dependent coverage
- ☐ Cancel my current coverage
- ☐ Cancel my dependents coverage

I understand that once I am dis-enrolled from a Cigna Dental plan, I will **not** be eligible for re-enrollment in a District sponsored dental plan at a later date.

Signature	Print Name	Date
Signature	Print Name	Date