Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Please fill out and carefully read all information below before signing and dating this disenrollment form.

Instead of sending a disenrollment request, you can contact our Customer Service Department at 1-855-695-7037 if you need additional information. Our office hours are Monday through Friday, 8:00am to 8:00pm; or if you are calling from October 1-February 14, representatives are available to assist you 7 days a week from 8:00am to 8:00pm. TTY users should call 1-800-421-1220.

Last Name: First Name: Middle Initial:		☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Member ID:		
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )

By completing this disenrollment request, I agree to the following:

I understand that I am disenrolling from my **Medicare Supplement Plan**.

Signature *_____ Date: _____

*Or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides. If signed by an authorized individual, 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 Medicare.

If you are the authorized representative, you must provide the following information:
Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____