

Medicare Advantage Disenrollment Request

If you request disenrollment, you must continue to get all medical care from MVP Health Care® (MVP) until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of the MVP network. We will notify you of your effective date after we get this form from you.

Section 1: Member Information

Name <i>(last, first, middle initial)</i>	Sex ☐ Male ☐ Female	Date of Birth <i>(MM/DD/YYYY)</i>
Phone Number ()	Medicare Number - -	MVP Member ID Number

Section 2: Reason(s) for Disenrollment

Typically, you may disenroll from a Medicare Advantage plan only during the Annual Enrollment Period, October 15–December 7 each year, or during the Medicare Advantage Open Enrollment Period, January 1–March 31 each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside these periods.

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.

Check each statement below that applies to you.

- ☐ I am joining a different Medicare plan during the Annual Election Period, October 15–December 7.
- ☐ I am changing to a different Medicare plan or Original Medicare during the Medicare Advantage Open Enrollment Period.
- ☐ I recently moved outside of the MVP service area for my current plan. I moved on *(date)*.
- ☐ I am joining employer or union coverage on *(date)*.
- ☐ I recently had a change in my Medicaid *(started receiving Medicaid, had a change in level of Medicaid assistance, or lost Medicaid)* on *(date)*.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage *(started receiving Extra Help, had a change in level of Extra Help, or lost Extra Help)* on *(date)*.
- ☐ I have both Medicare and Medicaid *(or my state helps pay for my Medicare premiums)* or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a long term care facility *(for example, a nursing home)*. I moved/will move into/out of the facility on *(date)*.
- ☐ I am joining a PACE program on *(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 *(date)*.

If none of these statements apply to you or you're not sure, please contact the MVP Medicare Customer Care Center at the phone number on the back of this form.



625 State Street
Schenectady, NY 12305
mvphealthcare.com

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*Member Name**MVP Member ID Number***Section 3: Attestation and Signature**

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

If I have enrolled in another Medicare Advantage plan or Medicare Prescription Drug plan, I understand Medicare will cancel my current membership in an MVP 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.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this form means that I have read and understand the contents of this form. If signed by an authorized representative (as described above), this signature certifies that:

- (1) This person is authorized under state law to complete this form and
- (2) Documentation of this authority is available upon request by Medicare.

I attest that the information I have provided on this form is true to the best of my knowledge.

*Member or Authorized Representative Signature**Date*

If you are the authorized representative, sign above and provide the information below about yourself.

Name

Relationship to Member

Address

Phone Number
()**Return this completed form by mail to:**

Attn: Medicare Enrollment, MVP Health Care, 625 State Street Schenectady, NY 12305

If you have questions contact the MVP Medicare Customer Care Center at: **1-800-665-7924** (TTY 711)