



## HEALTH NET MEDICARE PROGRAMS GROUP DISENROLLMENT FORM

If you request disenrollment, you must continue to receive all medical care from Health Net Medicare Programs until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of the Health Net Medicare Programs network. We will notify you of your effective date after we have received this form from you.

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Subscriber / R #			
Group # (please refer to ID card)			
Birth date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: ( )	

Effective \_\_\_\_/\_\_\_\_/\_\_\_\_ (must be the 1<sup>st</sup> day of the month)

Reason:  Premium too high  Claims payment unsatisfactory  Customer service unsatisfactory  
(optional)  Moving out of a Health Net Medicare Programs' service area Date of move: \_\_\_\_\_  
 Other reason: \_\_\_\_\_

### Are you transitioning from one Health Net Medicare Programs Plan to another Health Net Medicare Programs Plan?

<input type="checkbox"/> Yes, I am transferring to a Health Net Medicare Advantage HMO Plan.
<input type="checkbox"/> Yes, I am transferring to a Health Net Medicare COB/PDP Plan.
<input type="checkbox"/> Yes, I am transferring to a Health Net Medicare Individual Plan.
<input type="checkbox"/> No

Please allow 7-10 business days for processing. To check the status of the cancellation please call the appropriate Medicare Member Services number below:

Health Net Medicare Advantage HMO Plans  
1-800-275-4737 (TTY dial 711), 8:00 a.m.- 8:00 p.m., 7 days a week

Health Net Medicare COB/PDP Plans  
1-800-806-8811 (TTY dial 711), 8:00 a.m.- 8:00 p.m., 7 days a week

Health Net Medicare PFFS Plans  
1-800-977-8221 (TTY dial 711), 8:00 a.m.- 8:00 p.m., 7 days a week

**If your spouse is currently enrolled in a Health Net Medicare plan and wishes to disenroll, a separate disenrollment must be completed.**

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

On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership in Health Net Medicare Programs. 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 do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

**Your 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 (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 Health Net Medicare Programs or by Medicare.

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

<b>Name:</b> _____
<b>Address:</b> _____
<b>Phone Number:</b> (____) _____ - _____
<b>Relationship to Enrollee:</b> _____

**RETURN FORM TO:**

San Bernardino County  
Employee Benefits and Services Division (EBSB)  
157 West Fifth Street, First Floor  
San Bernardino, CA 92415-0440