



## SENIOR ADVANTAGE DISENROLLMENT FORM

This form is to be completed for each member of your family who wishes to discontinue membership in the Kaiser Permanente Senior Advantage program. **If you join another Medicare Advantage or Medicare Prescription Drug Plan, you do not need to complete this form. Once you enroll in another Medicare Advantage/Medicare Prescription Drug Plan, your current membership in Senior Advantage will be terminated automatically. If you wish to enroll in a Medicare Supplement Plan/Medigap Plan, you must complete this disenrollment form.** If you have any questions, please call the Kaiser Permanente Member Service Call Center toll free at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, from 8 a.m. to 8 p.m. Please return this form to the address below.

If you request disenrollment, you must continue to receive all medical care as usual through Kaiser Permanente, until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente's network.

When enrolled in the Kaiser Permanente Senior Advantage plan, you can make plan changes only at certain times during the year unless you meet certain special circumstances. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above. We will notify you of your effective date of disenrollment in writing after we have received this form from you.

### PLEASE TYPE OR PRINT USING BLACK OR BLUE INK

KAISER PERMANENTE MEDICAL RECORD #	LAST NAME	FIRST NAME	MI
	STREET ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	HOME PHONE NUMBER	

### Please read carefully before signing and dating this disenrollment form.

**For Individual Plan members only:** I understand that my disenrollment from Senior Advantage terminates all coverage through Kaiser Permanente, including Advantage Plus if applicable, effective the date of disenrollment. I understand that my current membership in Senior Advantage will be terminated automatically on the effective date of enrollment in another Medicare Health Plan/Medicare Prescription Drug Plan.

**For Employer Group/Trust Fund members only:** I understand that my disenrollment from Senior Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process. I understand that my current membership in Senior Advantage will be terminated automatically on the effective date of enrollment in another Medicare Health Plan (or a Medicare Prescription Drug Plan if your Senior Advantage plan includes Part D coverage).

**For all members:** 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 form and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

#### Authorized representative must provide the following information:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship to Enrollee \_\_\_\_\_

H0524\_2806000702 (02/27/2008)  
SKU # 3306-0002-07

**RETURN FORM TO:**

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