

DISENROLLMENT FORM

If you request disenrollment, you must contin to verify your disenrollment before you seek n we get this form from you.	-	-						
Last Name	First Name			Middle Initial	Mr.	Mrs.	Miss	Ms.
CareAdvantage ID Number								
Date of Birth (MM/DD/YYYY)	Male Sex	Female	Home Phone #		_			
Please carefully read and complete the f	ollowing information befo	re signing and da	ting this disenrollme	ent form:				
If I have enrolled in another Medicare Advanta CareAdvantage (HMO D-SNP) on the effective understand that if I am disenrolling from my I pay a higher premium for this coverage.	date of that new enrollment.	I understand that I r	might not be able to en	roll in another p	lan at	this tir		
Your Signature*		Date						
*Or the signature of the person authorized to above), this signature certifies that: 1) this pe available upon request by CareAdvantage (HM	rson is authorized under State		, ,					
If you are the authorized representative, you r	nust provide the following info	ormation:						
Name								
Address								
Phone #								
Relationship to Enrollee								
Reason for disenrollment (optional):								

H6019_DisenrollmentE

Attestation of Eligibility for an Election Period

8:00 p.m.

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

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. ☐ I recently had a change in my Medi-Cal (newly got Medi-Cal, had a change in level of Medi-Cal assistance, or lost Medi-Cal) on (insert date) . ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ______. ☐ I have both Medicare and Medi-Cal (or my state helps pay for my Medicare premiums) or I get Extra Help paying for 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 or long-term care facility). I moved/will move into/out of the facility on (insert date) ______. ☐ I am joining a PACE program on (insert date) . ☐ I am joining employer or union coverage on (insert 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 (insert date) If none of these statements applies to you or you're not sure, please call the CareAdvantage Unit at 1-866-880-0606 (toll free) or 650-616-2174. TTY users can use the California Relay Service (CRS) at 1-800-735-2929 (TTY). You can call us Monday through Sunday, 8:00 a.m. to