KAISER PERMANENTE®
Senior Advantage

SENIOR ADVANTAGE DISENROLLMENT FORM
FOR MEMBERS OF EMPLOYER GROUP HEALTH PLANS

This form is to be completed for each member of your family who wishes to disenroll from Kaiser Permanente Senior Advantage Plan. If you have any questions, please call your local Kaiser Permanente Health Plan Member Services Department.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK

Kaiser Permanente Medical Record No.	Last Name	First Name	MI
Medicare Claim No.	Street Address		
Telephone Number ( )	City	State	Zip

PLEASE READ AND FILL IN YOUR REQUESTED DATE OF DISENROLLMENT

I understand that my disenrollment from Kaiser Permanente Senior Advantage Plan may affect my Employer Group coverage. ***This disenrollment does not terminate my membership, which is sponsored by my group. To terminate membership, please contact your group for information.***

I understand that I must continue to use Kaiser Permanente for all of my health care except for emergencies, urgent care, and dialysis while temporarily outside of the service area and authorized referrals until the date of my disenrollment.

I understand that if I am requesting a disenrollment date in the past and my requested date is approved, any pending appeals will be dismissed, and I relinquish all further appeal rights pertaining to charges incurred on or after the requested disenrollment date. I also understand that I am financially liable for the usual Medicare deductibles and co-insurance for services received during the retroactive period.

Reason for disenrollment:

☐ Permanent Move _____ (Date of Move) ☐ Enrollment in Another Plan ☐ Return to Original Medicare

☐ Other (Explain) _____

Note to beneficiary: If this is the first time you have ever enrolled in a Medicare + Choice plan, and if you are disenrolling from Senior Advantage within 12 months of your effective date of enrollment, then you may be guaranteed issuance of certain Medigap coverage. You will have 63 days from the date of disenrollment to enroll in a Medigap plan. You may contact your State Insurance Department or Insurance Counseling Agency to get more information about the availability of Medigap insurance in your state.

MY REQUESTED DATE OF DISENROLLMENT _____ / _____ / _____

PLEASE SIGN HERE (Your signature or signature of guardian or conservator)

Signature: _____ **Date:** _____

***Representative Signature:** _____ **Relationship:** _____

*If this is being submitted by a guardian or conservator, please attach legal documents establishing guardianship.

Return the white signed form to: Kaiser Permanente, P.O. Box 232400, San Diego, CA 92193-9919