



# Blue Cross MedicareRx Medicare Prescription Drug Plan Disenrollment Form

**Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of the effective date of your disenrollment after we receive this form from you.**

Last name		First name		MI	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Permanent residence street address (Cannot use P.O. Box)		City		State	ZIP code
Member identification number	Date of birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home phone number (       )		

**By completing this disenrollment request, I agree to the following:**

Anthem Blue Cross will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Anthem Blue Cross network pharmacies in order to receive the highest level of my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare Prescription Drug Plans, unless I qualify for a special circumstance.

I understand that if my employer or union sponsor has been paying a Late Enrollment Penalty (LEP) for Part D on my behalf, I will now be responsible for paying this penalty amount myself.

I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not enroll in another Medicare Prescription Drug Plan at this time, or within 63 days of my date of termination, I may have to pay a penalty for this coverage in the future.

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), the 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 Anthem Blue Cross or Medicare.

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

Name (printed) \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Enrollee \_\_\_\_\_  
(Street address) (City) (State) (ZIP Code)