CHRISTUS Health Plan

DISENROLLMENT FORM

If you request disenrollment, you must continue to get all medical care from CHRISTUS Health Plan until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of CHRISTUS's network. We will notify you of your effective date after we get this form from you.

Last name: First Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Medicare Number:			
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )	

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

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in CHRISTUS Health Plan Generations/Generations Pus (circle one) on the effective date of that new enrollment. 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 want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your Signature*: _____ **Date:**_____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. 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 <plan name> or by Medicare.

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

Name:_____
Address: _____
Phone number: _____
Relationship to Enrollee: _____

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 Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) 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 Medicaid 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 get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ 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) _____ .

Please call us at 1-844-282-3026. TTY users should call 711. Member Services is open 8am - 8pm local time, 7 days per week from October 1st – March 31st and 8am-8pm local time Monday –Friday April 1st- September 30th.
Thank you.