Anthem Medicare Preferred (PPO)

Employer Group Health 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.

Employer or Union Name: **Laborers Health and Welfare Trust Fund for Northern California**	Group # **CAEGR010**	Requested Disenrollment Date: (_ _/_ _/ _ _ _ _) MM/DD/YYYY	
Last Name:	First Name	MI	☐Mr. ☐Mrs. ☐Ms.
Permanent Residence Street Address (P.O. Box is not allowed)	City	State	ZIP Code

Member Identification Number	Date of Birth (_ _/_ _/ _ _ _ _) MM/DD/YYYY	☐Male ☐Female	Home Phone Number (____) -____ - _____

Reason(s) for Disenrollment (Check all that apply):

☐Moving out of the area.	☐Medical copayments too high.	☐Questions not satisfactorily answered by Customer Service.
☐Going to a Nursing home.	☐Some needed medical services not covered.	☐Issues with sales representative.
☐Going to Original Medicare.	☐Drugs not covered by plan formulary.	☐Problems accessing specialists.
☐Going to Medicaid.	☐Did not like PCP/Problems with PCP.	☐Too long a wait when scheduling appointments.
☐Did not intend to enroll.	☐Questions/Concerns not addressed by my doctor.	☐Could not get health care services when sick.
☐Purchased a Medicare Supplement policy.	☐Office wait too long.	☐Friends, family and/or doctor recommended.
	☐Provider's termination.	☐Other reason:_____

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

I understand that Medicare will automatically cancel my current membership in my plan as of the date my enrollment in another Medicare Advantage or Medicare Prescription Drug Plan is effective. I understand that I might not be able to enroll in another plan at this time. I also understand that if I disenroll from my Medicare prescription drug coverage and do not enroll in other such coverage at this time, I may have to pay a higher premium for that coverage in the future.

Signature:	Today's Date:

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

Name_____

Address_____

City_____State_____ZIP Code_____

Phone Number (___) - ___ - _____ Relationship to Enrollee _____

Please return this disenrollment form to:

Laborers Funds Administrative Office of Northern California, Inc.
5672 Stoneridge Drive, Suite 100
Pleasanton, CA 94588

Anthem Blue Cross Life and Health Insurance Company is a LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem Insurance Companies, Inc., operating in California as Anthem BC Health Insurance Company (Anthem BC Health), is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the LPPO plan(s) noted above or herein. Anthem BC Health is the risk-bearing entity licensed under applicable state law to offer the LPPO plan(s) noted. Anthem BC Health has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the LPPO plan(s) available in this region. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

It’s important we treat you fairly
That’s why we follow Federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498 or by email to SeniorG&AIntake@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language
Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Customer Service number on the back of your ID card.

English:
You have the right to get this information and help in your language for free. Call the Customer Service number on your ID card for help. (TTY/TDD: 711)

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711) .

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید . برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی تان درج شده است، تماس بگیرید . **(TTY/TDD: 711)**

Hindi

आपके पास यह जानकार~ और मदद अपनी भाषा म~ मुफ़्त म~ प्राप्त करने का अ~धकार है। मदद के ~लए अपने ID काडर् पर सदस्य सेवाएँ नंबर पर कॉल कर~।(TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、ID カードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Laborers Pension Trust Fund for Northern California
Laborers Health and Welfare Trust Fund for Northern California
5672 Stonridge Drive Suite 100◆Pleasanton, CA 94588
Telephone: (707) 864-2800 ◆ Toll-free: (800) 244-4530

Authorization / Election

Please read all four options below. Choose one and check-off the appropriate box.

☐ ***ENROLL IN RETIRED PLAN****: I hereby authorize the Board of Trustees of the Laborers Pension Trust Fund for Northern California to deduct the appropriate monthly charge from my monthly pension check for participation in the Retired Laborers Health and Welfare Plan which I have elected. I enclose the completed Retired Plan Benefit Application Form. I understand that I may cancel this authorization at any time by providing the Fund Office written notice* ***60 days in advance*** *of the first day of the month I want coverage to terminate.*

☐ ***WITHDRAWAL FROM RETIRED PLAN****: I do not wish to participate in the Retired Laborers Health and Welfare Plan.* ***I UNDERSTAND THAT I MAY NOT BE GIVEN THE OPPORTUNITY TO ELECT RETIRED LABORERS HEALTH AND WELFARE COVERAGE AGAIN****. You should be aware that if you are married and elect the "Joint-and-Survivor Pension" Pension form of payment but you elect not to participate in the Health and Welfare Plan, your surviving spouse will not be eligible to participate in that Plan following your death.*

☐ ***CONTINUE ACTIVE COVERAGE THROUGH COBRA****: I wish to continue participating in the Active COBRA Laborers Health and Welfare Plan at this time, and hereby authorize the Board of Trustees of the Laborers Pension Trust Fund for Northern California to deduct the appropriate monthly charge from my monthly pension check. I reserve the right to participate in the Retired Laborers Health and Welfare Plan at a later time and understand that I must provide a written authorization to the Fund Office* ***within 30 days*** *from the date the Active COBRA Plan expires.*

☐ ***ENROLLMENT DEFERRAL****: I wish to defer enrollment in the Retired Laborers Health and Welfare Plan at this time because I have other health coverage or a health insurance policy or program, including COBRA Continuation Coverage, individual insurance, Medicaid or other public program, other than Medicare* ***(please attach a copy of proof of coverage)****. To reestablish my eligibility, I understand that I must enroll in the Retired Laborers Health and Welfare Plan* ***within 60 days*** *after termination of my other coverage and I must provide the Fund proof of termination of other health coverage.*

Retiree's Signature _____ **Date Signed** _____

PRINT Name _____ **Social Security Number** _____