



Kaiser Permanente Medicare Health Plan DISENROLLMENT FORM

Each individual requesting disenrollment will need to complete their own form. If you have any questions, call Kaiser Permanente at the phone number listed below for your region, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

California:	1-800-443-0815	Mid-Atlantic States:	1-888-777-5536
Colorado:	1-800-476-2167	Northwest:	1-877-221-8221
Georgia:	1-800-232-4404	Washington:	1-888-901-4600
Hawaii:	1-800-805-2739		

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente or a Kaiser Permanente network provider, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente’s network. We will notify you of your effective date of disenrollment after we get this form from you.

PRINT YOUR ANSWERS USING BLACK OR BLUE INK AND FILL IN CHECK BOXES WITH AN X

Please indicate which Kaiser Permanente **region** you reside in:

CALIFORNIA COLORADO GEORGIA HAWAII MID-ATLANTIC STATES NORTHWEST WASHINGTON

Kaiser Permanente Medical/Health Record#:

Medicare #:

LAST Name:

FIRST Name:

MI:

Birth Date: (mm/dd/yyyy)

Home Phone Number:

Mobile Phone Number:

Permanent Residence Street Address (P.O. Box is not allowed):

City:

County:

State:

ZIP Code:

Mailing Address, if different from your permanent address (P.O. Box allowed)

Street Address

City:

County:

State:

ZIP Code:

Email Address:

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 this period. If you have questions about the times you may disenroll from our Plan, call us at the number listed above.

SELECT A DISENROLLMENT REASON BELOW

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 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 am requesting a disenrollment date of (insert date) with the understanding that this must be approved by CMS.
- 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) .
- I have moved out of the Kaiser Permanente service area on (insert date) . I am requesting a disenrollment date of with the understanding that this must be approved by CMS.
- I have joined another plan with creditable prescription drug coverage (coverage as good as Medicare's) on (insert date) .
- My employer group coverage has ended or will transfer to a new health care plan on (insert date) . I am requesting a disenrollment date of with the understanding that this must be approved by CMS.
- I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my disenrollment request because of the disaster. Insert what emergency or major disaster and the date
- Other - Please explain

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

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente 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.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Medicare Advantage/Senior Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Medicare Advantage/Senior Advantage for Federal employees.

I understand that my signature (or the signature of the person authorized to act on my behalf) on this form means that I have read and understand the contents of this form. If signed by an authorized representative (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 Medicare.

Signature:

Today's Date:

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

Name:

Address:

Phone Number:

Relationship to Member:

Return the signed form to:

Kaiser Permanente - Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

You can also FAX or EMAIL your completed form to:

FAX: **1-855-355-5334**

EMAIL: **KPMedicareEnrollments@kp.org**

Advance notification for terminating group Medicare members

Regulatory advance notice requirements for terminating Medicare members

The Centers for Medicare & Medicaid Services (CMS) requires that group members in Medicare Advantage plans receive written notice from their employer's plan at least 21 days prior to termination.

- Because of this advance notice requirement, Kaiser Permanente Senior Advantage or Medicare Plus plan group members may no longer be terminated retroactively.
- So that we can comply with the requirements set by CMS, employer groups must notify Kaiser Permanente at least 30 days before the effective termination date for members in Kaiser Permanente Senior Advantage or Medicare Plus plans.

Save costs by providing advance notice for terminating Medicare members

Employers are responsible for premiums for each month an affected member remains on the group plan.

- Notifying Kaiser Permanente at least 30 days prior to the requested member termination date allows us adequate time to provide the member with 21 days' advance notice as required by CMS, and to disenroll the member from your group health plan by the desired termination date.
- If notification is not received within the 30-day time frame, the employer will be charged the member premium for an additional month.

To avoid additional charges associated with coverage extensions beyond the requested termination date:

- Have the member provide us with a signed Medicare disenrollment form or written request prior to the desired termination date for Kaiser Permanente Senior Advantage or Medicare Plus plans.
 - If the member sends their form or written request to the employer group, the employer group should date-stamp it and forward it to Kaiser Permanente.

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For more information about CMS termination requirements or our group retirement health plans, please contact your Kaiser Permanente account manager.

- As required by CMS, once we receive this form or written request, we'll notify the member about their termination by the group and describe their Medicare coverage options.
- Termination will occur on the first day of the month following the 30-day notification period. For example, if notification is received on February 25, the termination date would be April 1. If notification is received on March 8, the termination date would be May 1.
- Terminated group members will be converted to a Kaiser Permanente individual Medicare plan, unless the member:
 - is ineligible
 - requests disenrollment (member must submit a disenrollment form or a signed written request)
 - enrolls in a non - Kaiser Permanente Medicare Advantage or Part D plan
 - enrolls in a Medicare supplement policy (member must submit a disenrollment form or a signed written request)
 - has other Kaiser Permanente health plan coverage

Additional information

Retroactive termination for enrollment in another Medicare plan

If a member voluntarily enrolls in another Medicare Advantage or Medicare Cost plan during the 30-day notification period, CMS will permit a retroactive termination to the effective date that the new coverage began. In this case, CMS will auto-disenroll the member from Kaiser Permanente.

Termination for dependents

This policy applies to any employee, retiree, or dependent enrolled in a Kaiser Permanente Senior Advantage or Medicare Plus plan, including Medicare-eligible dependents of non-Medicare subscribers.

Help for your retirees and you

If you have any questions about Medicare terminations, please contact your account manager. Retirees who have questions about their plan may call **888-241-1457** or **800-777-1370** (TTY for the deaf, hard of hearing, or speech impaired), seven days a week, 8 a.m. to 8 p.m. Pacific time.

Kaiser Foundation Health Plan, Inc., 1950 Franklin St., Oakland, CA 94612, 510-987-1000 / Kaiser Foundation Health Plan, Inc., 393 E. Walnut St., Pasadena, CA 91188, 626-405-5000 / Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247, 303-338-3800 / Kaiser Foundation Health Plan of Colorado, 1975 Research Pkwy., Suite 250, Colorado Springs, CO 80920, 719-867-2100 / Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Rd. NE, Atlanta, GA 30305, 404-364-7000 / Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813, 808-432-5955 / Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852, 301-816-2424 / Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232, 503-813-2800 / Kaiser Foundation Health Plan of Ohio, North Point Tower, 1001 Lakeside Ave., Suite 1200, Cleveland, OH 44114, 216-621-5600.

Information may have changed since publication.