Health Plans

2019 Request for Disenrollment Form

Mail the completed form to the address below:

Enrollment Department
950 N. Meridian Street Suite 400
Indianapolis, Indiana 46204

Or fax the completed form to: 317.968.1331

If you request disenrollment, you must continue to receive all medical care from Indiana University Health Plans until the effective date of disenrollment. To verify your disenrollment before you seek medical services outside of IU Health Plans' network, please call our IU Health Plans Customer Solutions Center, at 1.800.455.9776, seven days a week from October 1 - March 31, 8 am - 8 pm, and starting April 1 – September 30, please call Monday through Friday from 8 am to 8 pm. TTY users should call 1.800.743.3333 (Relay Indiana). A representative will be available to assist you. We will notify you of your disenrollment date after we have received this form from you.

Last Name	First Name	Middle Initial	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Member ID			
Birth date	Sex ☐M ☐F	Home Phone number	
Permanent Street Address	City	State	ZIP Code

Disenrollment from an IU Health Medicare Advantage Plan will terminate any selected Optional Supplemental Dental coverage.

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 from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Health Plans

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 am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date).
- ☐ I recently was released from incarceration. I was released on (insert date).
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)

  _____.
- ☐ 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 my 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 recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
  I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date)
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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)

Health Plans

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ I want to only disenroll from the Optional Supplemental Dental Benefits (listed below). I understand that I will remain enrolled in the IU Health Medicare Advantage Plan.

- ☐ Dental Basic 750
- ☐ Dental Enhanced 1000
- ☐ Dental Enhanced 1500

If none of these statements applies to you or you're not sure, please contact IU Health Plans Customer Solutions Center at 317.963.9700 or 1.800.455.9776, seven days a week from October 1 - March 31, 8 am - 8 pm, and starting April 1 – September 30, please call Monday through Friday from 8 am to 8 pm. TTY users should call 1.800.743.3333 (Relay Indiana) to see if you are eligible to disenroll. A representative will be available to assist you.

Please carefully read and complete the following information before signing and dating this disenrollment form:
On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership with Indiana University Health Plans. 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 do not enroll in such coverage at this time, I may have to pay a higher premium 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), 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 IU Health Plans, Inc. or by Medicare.

Health Plans

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

Name: _____

Address: _____

City, State, Zip_____

Phone Number: (___) ____- _____

Relationship to Enrollee _____

ATTENTION: Our Customer Solutions Center has free language interpreter services for non-English speakers. Call 800.455.9776 (TTY: 800.743.3333).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.455.9776 (TTY: 800.743.3333).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800.455.9776 (TTY: 800.743.3333). >

<IU Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

IU Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

IU Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民 族血統、年齡、殘障或性別而歧視任何人。