Blue Shield Rx Plus (PDP) and Blue Shield Rx Enhanced (PDP) Disenrollment form

Please fill out and carefully read all the information below before signing and dating this disenrollment form. We will notify you of your effective date after we get this form from you. Instead of sending a disenrollment request to Blue Shield of California, you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, to disenroll by telephone. **TTY** users should call **(877) 486-2048**.

Member ID:		
Last name:	First name:	Middle initial:
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	
Home Phone Number:		

By completing this disenrollment request, I agree to the following:
Blue Shield Rx Plus or Blue Shield Rx Enhanced will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Blue Shield Rx Plus or Blue Shield Rx Enhanced network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I don't have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

Your signature*:	**Date: (MM/DD/YYYY)**

*Or the signature of the person authorized to act on your behalf 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 Medicare.

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

Last name:	First name:	Middle initial:
Street address:		
City:	State:	ZIP code:
Phone number:		
Relationship to enrollee:		

Typically, you may disenroll from a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to disenroll from a Medicare prescription drug 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 MM/DD/YYYY)

  _____.

- ☐ 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 MM/DD/YYYY)

  _____.

- ☐ 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 MM/DD/YYYY)

  _____.

- ☐ I am joining a PACE program on (insert date MM/DD/YYYY)

  _____.

- ☐ I am joining employer or union coverage on (insert date MM/DD/YYYY)

  _____.

- ☐ 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 MM/DD/YYYY)

  _____.

If none of these statements applies to you or you're not sure, please contact Blue Shield Rx Plus Plan or Blue Shield Rx Enhanced Plan Customer Service at **(888) 239-6469** (**TTY: 711**) to see if you are eligible to disenroll. We are open 8 a.m. to 8 p.m. Pacific time, seven days a week.

Email, mail, or fax your completed and signed form to:

Email: WHMembership@blueshieldca.com
Mail: Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856
Fax: (877) 251-3660