PO Box 14088
Lexington, KY 40512-4088

aetna®

Disenrollment Form

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

Note: For members disenrolling from an **Individual Medicare Advantage plan**, you can disenroll by phone instead of sending a disenrollment request to Aetna Medicare. To disenroll by phone, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **711.**

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

First Name Last name MI	Ms. Mr. Mrs. Miss
Member ID	Medicare claim number
Birth date / Sex	Phone number where we can reach you

Check all election reasons that apply	
Both Medicare and Medicaid or my state help pay for my Medicare premiums.	
I get extra help paying for Medicare prescription drug coverage.	
I no longer qualify for extra help paying for Medicare prescription drugs.	
I am gaining coverage through an employer or union.	
Annual enrollment period (10/15 through 12/7).	
Medicare Advantage disenrollment period (1/1 through 2/14).	
I am moving into, live in, or recently moved out of a long-term care facility.	
I have recently been incarcerated .	
Member deceased.	
Member is in the 12 Month Trial Period and prefers to rejoin the Medigap policy.	

Example of an invalid election: *"Unable to pay premiums or plan too costly"*

By completing this disenrollment request, I understand the following:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand that Medicare will cancel my current membership in **Aetna Medicare** on the effective date of that new enrollment.

I understand that:

- **There are limited times in which I will be able to disenroll from my Aetna Medicare MA/MAPD Plan**
- **If I do not qualify for one of the election reasons above, my request may be denied.**
- I might not be able to enroll in another plan at this time.
- 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.

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
2. Documentation of this authority is available upon request by Aetna Medicare or Medicare.

If you are the authorized representative, you must provide the following information:
Name: _____
Address: _____
Phone number: _____
Relations to enrollee: _____