PO Box 14088
Lexington, KY 40512-4088

aetna®

PDP Disenrollment Form

Please carefully read and complete the following information. Then sign and date this disenrollment form.

Note: For members disenrolling from an **Individual Medicare Prescription Drug 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 fill all prescription drugs through your Aetna Medicare Plan until the effective date of disenrollment. 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 (10/15-12/7).	
I am moving into, live in, or recently moved out of a long-term care facility.	
I have recently been incarcerated .	
Member deceased.	

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

By completing this disenrollment request I agree to the following:

Aetna Medicare will notify me of my disenrollment date after they **receive** this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions **at one of my network pharmacies available under my Aetna Medicare PDP Plan.**

I understand that:

- **There are limited times in which I will be able to disenroll from my Aetna Medicare PDP Plan.**
- **If I do not qualify for one of the election reasons above, my request may be denied.**
- There are limited times in which I will be able to join other Medicare plans, unless I qualify for a special circumstance.
- **When I disenroll** from my Medicare Prescription Drug Plan , if I don't have other coverage as good as Medicare, I may have to pay a late enrollment f 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
2. Documentation of this authority is available upon request by the Aetna Medicare PDP Plan or Medicare

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