SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.877.998.0998 | TTY 711

Medicare Advantage Request for Disenrollment

If you request disenrollment, you must continue to get all medical care from Security Health Plan until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services out of Security Health Plan's network. We will notify you of your effective date after we get this form from you.

Please print			Subscriber number
Last name	First name		Middle initial
Street address			
City	State	ZIP	County
Telephone number ( ) -	Birthdate / /		Sex: ☐ Male ☐ Female
Medicare number	Requested termination date / /		

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 Disenrollment Period from January 1 through February 14 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage 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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____/_____/_____.
- ☐ 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) _____/_____/_____.

If none of these statements applies to you or you're not sure, please contact Security Health Plan at 1-877-998-0998 (TTY users call 711) to see if you are eligible to disenroll. We are open 7 days a week from 8 a.m. to 8 p.m.

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

I understand that I am not disenrolled from Security Health Plan's Medicare Advantage plan until my request is processed and approved by the Centers for Medicare and Medicaid Services (CMS).

I understand that I must use Security Health Plan providers except in emergent or urgent care situations until my disenrollment is confirmed. If I obtain routine care from out-of-network providers, this coverage is subject to higher out-of-network cost-sharing, with a few exceptions.

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in a Security Health Plan Medicare Advantage plan 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.

Your Signature*: _____ **Date:** _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. 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 Security Health Plan or by Medicare.

If you are the authorized representative (i.e. power of attorney, conservator, guardian), you must sign above and provide the following information:

Name _____

Address _____

City _____ **State** _____ **Zip code** _____

Phone number: (_____) _____

Relationship to enrollee _____

Please attach one of the following documents or **it will be requested by Security Health Plan:**

letters of guardianship; power of attorney (POA) with financial authority; or person designated in a written advance directive that authorizes application for insurance.

Please continue to page 3

Please tell us the reason(s) for your disenrollment so that we may use this information to help us continually improve our plans.

- ☐ Premiums are too high
- ☐ I'm moving out of the service area
- ☐ My doctor wasn't part of the plan network
- ☐ I received poor service from Security Health Plan
- ☐ Out-of-pocket costs are too high
- ☐ I qualified for Medicaid
- ☐ My agent recommended I switch plans
- ☐ Other _____

  _____
- ☐ I'm enrolling in a different plan *(specify plan name)* _____

  _____

What could we have done differently to keep your membership in Security Health Plan Medicare Advantage plan?

_____

_____

_____

Please return this form in the enclosed envelope to:

Security Health Plan of Wisconsin, Inc.
P.O. Box 8000
Marshfield, WI 54449-8000

or fax to: 715-221-9607