COMPANIONCARE/MEDICARE SUPPLEMENT DISENROLLMENT REQUEST

SISC GROUP PLAN

PLEASE PRINT IN INK

MEMBER NAME LAST	FIRST	MI.	MEMBER I.D.	
ADDRESS	CITY	STATE	ZIP	COUNTY
TELEPHONE #	SEX ٯ MALE ٯ FEMALE	DATE OF BIRTH		
MEDICARE #	GROUP #	SOCIAL SECURITY #		

PLEASE READ CAREFULLY AND COMPLETE THE INFORMATION BELOW BEFORE SIGNING AND DATING THE DISENROLLMENT FORM.

CURRENT HEALTH PLAN

( ) CompanionCare/Medicare Supplement

( ) I wish to disenroll from CompanionCare/Medicare Supplement.

When the medical portion of this plan is terminated then the Medicare Part D prescription drug plan is automatically terminated with the same termination date.

( ) I wish to enroll with the plan listed below.

NEW HEALTH PLAN (DISTRICT MUST OFFER PLAN)

( ) Health Net Seniority Plus ( ) Kaiser Senior Advantage

( ) Other_______________________________________ Effective Date_______________________________________

Requested disenrollment date: __________________________________

Disenrollment request must be 45 days advance notice. **No exceptions.**

Member Signature: ____ Date:_____________________

SISC USE ONLY

Date received:________________________________ Date submitted to Health Plan:

Processed by: ______________________________