



MEDICARE ADVANTAGE DISENROLLMENT REQUEST

SISC GROUP PLAN

PLEASE PRINT IN INK

MEMBER NAME LAST	FIRST	MI.	MEMBER I.D.	
ADDRESS	CITY	STATE	ZIP	COUNTY
TELEPHONE #	SEX ♂ MALE ♀ 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

Health Net Seniority Plus Kaiser Senior Advantage PacifiCare Secure Horizons

I WISH TO RETURN TO MEDICARE COVERAGE.
 I WISH TO DISENROLL FROM THE ABOVE HMO PLAN AND ENROLL WITH THE PLAN LISTED BELOW.

NEW HEALTH PLAN

Health Net Seniority Plus Kaiser Senior Advantage
 Other _____ Effective Date _____

Members who have requested disenrollment must continue to receive all medical care (except for emergencies, out-of-area urgent care, or authorized referrals) from their HMO plan until the effective date of the disenrollment.

Requested disenrollment date: _____

Medicare benefits may only be restored on the first of the month. The process to restore your Medicare benefits requires a minimum of thirty (30) days; therefore, this disenrollment form must be received by SISC at least thirty (30) days prior to the date you need your Medicare benefits restored.

Member Signature: _____ Date: _____

SISC USE ONLY

Date received: _____ Date submitted to Health Plan: _____

Processed by: _____