Member ID: «MemberID»

If you request disenrollment, you must continue to get all medical care from «PlanName» until the effective date of disenrollment. We will notify you of your effective date after we get this form from you.

Last name:	First Name:	Middle Initial:	Mr. Mrs. Miss. Ms.
Medicare #			
Birth Date:	Sex: M F	Home Phone Number: ( )	

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

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in SCAN 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, if I don't enroll in another Medicare Advantage plan with prescription drug coverage or Medicare prescription drug plan, or if I don't get creditable coverage as good as Medicare prescription drug coverage, I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

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 SCAN or by Medicare.

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee: _____

SCAN Health Plan is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

H9104_H5425_H5811_H9385_H5943_SCAN_6852_2011 CMS Approved 10182011

Member ID: «MemberID»

SCAN Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak Chinese or Spanish, language assistance services, free of charge, are available to you. Call 1-800-559-3500 (TTY: 711), 8 a.m.–8 p.m., 7 days a week from October 1 to February 14. From February 15 to September 30, hours are 8 a.m. to 8 p.m. Monday through Friday.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-559-3500 (TTY: 711), de 8 a.m. a 8 p.m., los siete días de la semana del 1 de octubre al 14 de febrero. Del 15 de febrero al 30 de septiembre el horario es de 8 a.m. a 8 p.m. de lunes a viernes.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-559-3500 (TTY: 711) 聯絡我們的會員服務部，服務時間：10月1日至2月14日，每週七天，每天上午8點至晚上8點；2月15日至9月30日：週一至週五，上午8點到晚上8點。