scan HEALTH PLAN®

Member ID:

If you request disenrollment, you must continue to get all medical care from your current plan 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.