Anthem
Health. Join In.

Anthem Medicare Preferred (PPO)
Employer Group Health Disenrollment Form

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of the effective date of your disenrollment after we receive this form from you.

Employer or Union name	Group #	Requested Disenrollment Date: (__ __/__ __/__ __ __ __) (MM/DD/YYYY)	
City of Manchester, NH	200079M002		
Last name	First name	MI	☐Mr. ☐Mrs. ☐Ms.
Permanent residence street address (P.O. Box is not allowed)	City	State	ZIP code

Member identification number	Date of birth (__ __/__ __/__ __ __ __) (MM/DD/YYYY)	☐Male ☐Female	Home phone number (____) ____ -- _____

Reason(s) for Disenrollment (Check all that apply)

- ☐Moving out of the area.
- ☐Going to a Nursing home.
- ☐Going to Original Medicare.
- ☐Going to Medicaid.
- ☐Did not intend to enroll.
- ☐Purchased a Medicare Supplement policy.
- ☐Medical copayments too high.
- ☐Some needed medical services not covered.
- ☐Drugs not covered by plan formulary.
- ☐Did not like PCP/Problems with PCP.
- ☐Questions/Concerns not addressed by my doctor.
- ☐Office wait too long.
- ☐Provider's termination.
- ☐Questions not satisfactorily answered by Customer Service.
- ☐Issues with sales representative.
- ☐Problems accessing specialists.
- ☐Too long a wait when scheduling appointments.
- ☐Could not get health care services when sick.
- ☐Friends, family and/or doctor recommended.
- ☐Other reason: _____

_____

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

I understand that Medicare will automatically cancel my current membership in my plan as of the date my enrollment in another Medicare Advantage or Medicare Prescription Drug Plan is effective. I understand that I might not be able to enroll in another plan at this time. I also understand that if I disenroll from my Medicare prescription drug coverage and do not enroll in other such coverage at this time, I may have to pay a higher premium for that coverage in the future.

Signature:	Today's Date:

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

Name _____

Address _____

City _____ State _____ ZIP code _____

Phone number (____) ____ – _____ Relationship to enrollee_____

Please return this disenrollment form to:
Anthem Blue Cross and Blue Shield
P.O. Box 110
Fond du Lac, WI 54936

A PPO plan with a Medicare contract.

Y0071_11_11951_I 02/08/2011

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

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