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OF NORTHERN CALIFORNIA
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ELECIÓN PARA TERMINAR/DEMORAR LA COBERTURA MÉDICA PARA JUBILADOS (PLAN MÉDICO KAISER INCLUYENDO KAISER SENIOR ADVANTAGE)

- Complete este formulario solo si desea cancelar la cobertura médica para usted y/o para su(s) dependiente(s)
- Si usted cancela su propia cobertura se cancelará la cobertura de su(s) dependiente(s)
- Ya que se cancele la cobertura de su(s) hijo(s) dependiente(s) no sera(n) elegible para reinscribirse en el plan medico

A partir de _____, eligo cancelar la cobertura médica para jubilados:

☐ Mia y de mi(s) dependiente(s), si lo(s) tengo.

☐ Solamente de mi(s) dependiente(s).
Escriba a continución el nombre del(los) dependiente(s) cuya cobertura se debe cancelar.

Nombre del 1er dependiente: _____

Nombre del 2o dependiente: _____

FAVOR DE LEER: Entiendo que <u>no se permitirá</u> que yo (y/o mi(s) dependiente(s)) me reinscriba en el Plan Médico para Jubilados de Carpenters en ninguna fecha futura después de que cancele esta cobertura, **<u>a menos que</u>**

- esté cancelando esta cobertura debido a que tengo cobertura bajo otro plan medico.
- no soy elegible para Medicare y he proporcionado un comprobante de inscripción en Medicare dentro de 60 días.
- he adquerido un nuevo dependiente mediante matrimonio, nacimiento, adopción o tutela legal y lo(s) inscribiré y proveeré la documentación requerida dentro 60 días de la fecha en que adquerí el/los nuevo(s) dependiente(s).

<u>Por favor indique la razón por la cual está cancelando/demorando la cobertura médica para jubilados:</u>

☐ Yo (o mi(s) dependiente(s)) tengo cobertura bajo otro plan médico. Entiendo que tendré 31 días para reinscribirme en el Plan Médico para Jubilados de Carpenters después de que termine la otra cobertura.

Nombre del empleador _____ Nombre del empleado

Nombre de la compañia aseguradora o del plan medico _____ Número del plan

☐ Yo (o mi(s) dependiente(s) tengo cobertura de Medicaid, un Programa estatal de Seguro Médico para Niños (Children's Health Insurance Program, CHIP), o de otro programa público que no sea Medicare. Entiendo que tendré 60 días para reinscribirme en el Plan Médico para Jubilados de Carpenters.

Nombre del jubilado (en letra de molde) _____ No UBC, de ID o de Seguro Social

Firma del jubilado _____ Fecha

KAISER PERMANENTE®

Kaiser Permanente Medicare Health Plan

DISENROLLMENT FORM

Each individual requesting disenrollment will need to complete their own form. If you have any questions, call Kaiser Permanente at the phone number listed below for your region, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

California:	**1-800-443-0815**	**Mid-Atlantic States:**	**1-888-777-5536**
Colorado:	**1-800-476-2167**	**Northwest:**	**1-877-221-8221**
Georgia:	**1-800-232-4404**	**Washington:**	**1-888-901-4600**
Hawaii:	**1-800-805-2739**		

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente or a Kaiser Permanente network provider, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente's network. We will notify you of your effective date of disenrollment after we get this form from you.

PRINT YOUR ANSWERS USING BLACK OR BLUE INK AND FILL IN CHECK BOXES WITH AN X

Please indicate which Kaiser Permanente **region** you reside in:

☐ **CALIFORNIA** ☐ **COLORADO** ☐ **GEORGIA** ☐ **HAWAII** ☐ **MID-ATLANTIC STATES** ☐ **NORTHWEST** ☐ **WASHINGTON**

Kaiser Permanente Medical/Health Record#:

Medicare #:

LAST Name:

FIRST Name:

MI:

Birth Date: (mm/dd/yyyy)

Home Phone Number:

Mobile Phone Number:

Permanent Residence Street Address (P.O. Box is not allowed):

City:

County:

State:

ZIP Code:

Mailing Address, if different from your permanent address (P.O. Box allowed)

Street Address

City:

County:

State:

ZIP Code:

Email Address:

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Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside this period. If you have questions about the times you may disenroll from our Plan, call us at the number listed above.

SELECT A DISENROLLMENT REASON BELOW

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I am joining a PACE program on (insert date) _____.
- ☐ I am joining employer or union coverage on (insert date) _____. I am requesting a disenrollment date of (insert date) _____ with the understanding that this must be approved by CMS.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I have moved out of the Kaiser Permanente service area on (insert date) _____. I am requesting a disenrollment date of _____ with the understanding that this must be approved by CMS.
- ☐ I have joined another plan with creditable prescription drug coverage (coverage as good as Medicare's) on (insert date) _____.
- ☐ My employer group coverage has ended or will transfer to a new health care plan on (insert date) _____. I am requesting a disenrollment date of _____ with the understanding that this must be approved by CMS.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my disenrollment request because of the disaster. Insert what emergency or major disaster and the date _____

  _____
- ☐ Other – Please explain _____

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

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente 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 and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Medicare Advantage/Senior Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Medicare Advantage/Senior Advantage for Federal employees.

I understand that my signature (or the signature of the person authorized to act on my behalf) on this form means that I have read and understand the contents of this form. If signed by an authorized representative (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 Medicare.

Signature:

Today's Date:

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

Name:

Address:

Phone Number:

Relationship to Member:

Return the signed form to:

Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

You can also FAX or EMAIL your completed form to:

FAX: **1-855-355-5334**

EMAIL: **8553555334@fax.kp.org**