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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 Senior Advantage (HMO) or
Kaiser Permanente Senior Advantage Medicare Medi-Cal (HMO SNP) Plan

DISENROLLMENT FORM

Northern California or Southern California Region

Each individual disenrolling will need to complete his/her own form. If you have any questions, please call Kaiser Permanente at **1-800-443-0815** (TTY **711** for the hearing/speech impaired), seven days a week, 8 a.m. to 8 p.m.

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente, 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 in writing after we get this form from you.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK			
KAISER PERMANENTE MEDICAL/ HEALTH RECORD #	LAST NAME	FIRST NAME	MI
	MAILING ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX: ☐ **M** ☐ **F**	HOME PHONE NUMBER	

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 Disenrollment Period from January 1 through February 14 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.

PLEASE SELECT A DISENROLLMENT REASON BELOW

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 have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ 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 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.
- ☐ Other – Please explain _____.

Y0043_N011108 approved
SKU 60134008 CA (01/2014)

Top original signed copy - Kaiser Permanente
Middle copy - Employer group/union/trust fund
Bottom copy - Keep for your records

Please carefully read and complete 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 Senior Advantage Plan 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.

If you have selected to have Medicare prescription drug coverage from Kaiser Permanente, by disenrolling from Kaiser Permanente Senior Advantage you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of the year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area you can call **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente 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 Senior Advantage for Federal employees.

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 Kaiser Permanente or by Medicare.

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

Name _____

Address _____

Phone _____

Relationship to enrollee _____

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This information is available in a different format by calling the number listed in the first paragraph.

Return the top, signed white copy to:

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

If required, send the middle copy to your employer group or union/trust fund. Keep the bottom copy for your records.