

Arkansas Blue Medicare Disenrollment Form

If you request disenrollment, you must continue to get all medical care and/or prescription drugs from Arkansas Blue Medicare until the effective date of disenrollment. Contact us to verify your disenrollment before you seek services outside of Arkansas Blue Medicare's network. We will notify you of your effective date after we get this form from you.



First name	Last name	Suffix	Middle initial
Medicare number - -		Prefix ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	
Birth date (MM/DD/YYYY) (/ /)	Sex ☐ M ☐ F	Phone number () -	

Disenrollment reason (please check appropriate box):

Typically, you may disenroll from a Medicare Advantage/prescription drug plan only during the Open Enrollment Period from October 15 through December 7 of each year or, for Medicare Advantage members, 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/prescription drug plan outside of these periods.

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 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 my Medicare 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 rehabilitation hospital). 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 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 am moving out of the Arkansas Blue Medicare service area.
- ☐ I am joining coverage through my spouse.
- ☐ I am returning to my previous Medigap coverage (For Medicare Advantage members).
- ☐ Other _____.

If none of these statements applies to you or you’re not sure, please contact Arkansas Blue Medicare at **1-844-463-1088** (TTY: **711**) to see if you are eligible to disenroll. From October 1 through March 31, our hours are 8:00 a.m. to 8:00 p.m. Central, seven days a week. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m., Monday through Friday.

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 Arkansas Blue Medicare 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 drug coverage and want Medicare drug coverage in the future, I may have to pay a higher premium for this coverage.

Signature*	Today’s date
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*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 Arkansas Blue Medicare or Medicare.

If you are the authorized representative, you must provide the following information:	
Name	Relationship to enrollee
Address	Phone number () -

Please mail the completed and signed disenrollment form to:
Arkansas Blue Medicare • P.O. Box 3648 • Little Rock, AR 72203 • Fax: 1-501-301-1927

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