220 Alexander St.
Rochester, NY 14607
www.mvphealthcare.com

Medicare Advantage Disenrollment Form

- If you request disenrollment, you must continue to get all medical care from MVP Health Care 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	Telephone Number ( )
Gender (circle one) Male / Female	Date of Birth (MM/DD/YYYY) / /	Medicare # _____-_____-_____		MVP Member ID #

Typically, you may disenroll from a Medicare Advantage plan only during the annual election 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 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 to disenroll.

☐I am joining a different Medicare plan during the Annual Election Period (Oct. 15 -Dec. 7).
☐I am changing to Original Medicare during the Medicare Advantage Disenrollment Period (Jan. 1 – Feb. 14).
☐I recently moved outside of the service area for my current plan. I moved on (date): _____
☐ I am joining employer or union coverage on (insert date) _____.
☐ 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) _____.

If none of these statements applies to you or you're not sure, please contact the MVP Medicare Customer Care Center at:

1-800-665-7924
TTY users may call 1-800-662-1220

Representatives are available to serve you, Monday – Friday, 8 am – 8 pm. From October 1 – February 14, call seven days a week from 8 am to 8pm.

Please Sign on Back

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 MVP Health Care 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.

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 from Medicare.

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

Name : _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee _____

Return this completed form to:

MVP Health Care
Attn: Medicare Enrollment
220 Alexander Street
Rochester, NY 14607