UnitedHealthcare®
GROUP DISENROLLMENT FORM

You must complete this form to leave (disenroll from) your plan.

Please speak with your former employer, union or trust group (plan sponsor) before completing this form. If you leave this plan you may lose benefits provided by your plan sponsor. Please read this form carefully and fill it out completely. You will need information from your Medicare card and your member ID card to complete the form. Make sure to sign and date the form before you send it to us. We will send you a letter to let you know the date you will be disenrolled from the plan.

Member Name	Medicare Claim Number (From Your Medicare Card)	Member ID Number
☐ Male ☐ Female	Date of Birth _____/_____/_____ mm dd yyyy	
Street Address		Suite/Apt
City	ZIP CODE	
Telephone Number ( )		
Requested Date of Disenrollment		
Reason for Disenrollment		

Attestations for Disenrollment

- I will continue to use the coverage from my plan until my disenrollment date.
- If I have enrolled in another Medicare Advantage or Medicare Prescription Drug plan, Medicare will cancel my current plan when my new plan is effective. (Note: you do not need to complete this form or return it to us. You will be automatically disenrolled from this plan when your new Medicare plan begins.)
- If I disenroll from a Medicare Advantage plan and do not enroll in another one, I will return to Original Medicare.

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- I understand that until my disenrollment is effective, I must continue to fill my prescriptions within network pharmacies to get coverage.
- If I disenroll from Medicare Prescription Drug coverage and want Medicare Prescription Drug coverage in the future, I may have to pay a higher premium.
- If I have not enrolled in a new plan already, I may not be able to enroll at this time. Medicare has rules about when I can change plans.
- I will be disenrolled from my current plan on the first day of the month after I return this form; unless I ask to be disenrolled on a later date. For example: if I return this form on April 30, the last day of the month, I may be disenrolled on May 1.

Contact us to verify your disenrollment before you seek medical services outside of the plan's network.

Member Signature*	Date

*Or the signature of the person authorized to make decisions for the member under the laws of the State where the member lives. If signed by an authorized person (as described above), this signature certifies that:

1. This person is authorized under State law to complete this disenrollment and,
2. Proof of this authority is available to UnitedHealthcare or to Medicare upon request.

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

Print Name	Signature	
Street Address		Suite/Apt
City	ZIP CODE	
Telephone Number ( )	Relationship to Member	

In order to complete your disenrollment, please fax or mail this completed form.

Mail: SBCERS, 3916 State St, Suite 100, Santa Barbara, CA 93105
Fax: 805-560-1086 Email: benefits@sbcers.org

If you have any questions, contact your plan sponsor or call Customer Service at the number listed on the back of your Member ID card.