UnitedHealthcare Group Disenrollment Form

Complete this form if you want 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.

Read the information below before completing, signing and dating this form. You will need information from your Medicare card and your member ID card to complete the form.

Last Name: _____ First Name: _____

Middle Initial: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Member ID Number: _____ Sex: ☐ M ☐ F

Medicare Claim Number (from Medicare card) _____

Birth Date: _____ /_____ /_____ Phone Number: (_____) _____

Requested Date of Disenrollment _____

Reason for Disenrollment _____

_____

By completing this disenrollment request, I agree to the following:

- I understand that until the date my coverage ends, I must continue to receive all medical care from the plan. I will only get my care from network doctors until my disenrollment date, except in an emergency situation.
- If I have signed up for another Medicare Advantage or Medicare Prescription Drug plan, I understand Medicare will end my current membership in the plan on the start date of that new plan and I do not need to complete this form.
- If I disenroll from a Medicare Advantage plan and do not enroll in another one, I will return to Original Medicare.
- If I haven't enrolled in a new plan already, I understand that I might not be able to sign up for another plan 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. Example: If I return the form on April 30, I may be disenrolled on May 1. The plan will send me a letter with the date my plan coverage ends after they get this form.

Please sign and date this form before sending it back to us.

Your 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 upon request by UnitedHealthcare or by Medicare.

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

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____

Relationship to Member: _____

Send your completed, signed and dated form back to us:

- By mail at:
  UnitedHealthcare
  P.O. Box 30769
  Salt Lake City, UT 84130-0769

- By fax at 1-888-950-1169

Questions? We're here to help.

If you have any questions, contact your plan sponsor or call the toll-free Customer Service number on the back of your member ID card.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。