



Dear Member,

Please read the important instructions in this letter regarding requesting disenrollment from UnitedHealthcare®.

Please look at the checklist below and see what situation applies to you. Each option will let you know what you'll need to do. If you need to use the disenrollment form, it's included with this letter.

- ☐ I want to switch to Original Medicare only. I don't want Medicare Prescription Drug coverage. Please complete and submit the disenrollment form.
- ☐ I want to enroll in (sign up for), or have already enrolled in another Medicare Prescription Drug plan or Medicare Advantage Prescription Drug plan. You don't need to use the form. When you enroll in one of these plans, Medicare will automatically end your current plan coverage.

How do I submit the disenrollment request?

If you want to disenroll from UnitedHealthcare, you may fill out the attached form, sign it and send it back to us at:

UnitedHealthcare
P.O. Box 30769
Salt Lake City, UT 84130-0769

You can also submit the form online or fax the form with a readable signature and date to us at 1-888-950-1169.

Instead of sending a disenrollment request to UnitedHealthcare you can also call Medicare at 1-800-633-4227, 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

If you have any questions, please call the number on the back of your member ID card.

For more information, see the next page.
More Information

If I complete and submit the disenrollment form, how will I know when I can disenroll or change plans?

After we receive your completed form, we'll let you know if you can disenroll. If you can, we'll send you a letter with the disenrollment date. The disenrollment date is the last day you are a member of a plan.

What should I do about filling prescriptions?

You can fill prescriptions at your plan's network pharmacies until the disenrollment date. The plan may not pay for prescriptions filled at out-of-network pharmacies, except in emergencies. After your disenrollment date, the plan won't cover your prescription drugs.

When can I change plans?

You can switch, disenroll from, or enroll in a Medicare plan from October 15 to December 7. This is the Annual Enrollment Period.

If you qualify for Extra Help, you may change plans once per quarter for the first 9 months of the year. If you lose Extra Help, you can change plans up to 3 months after you lost it or after you're notified that you no longer qualify (whichever is later).

How do I find out about other Medicare plans in my area?

Call the number on the back of your ID card to find out if we have other plans available in your area. You can also visit www.medicare.gov or call Medicare at 1-800-633-4227, TTY 1-877-486-2048, 24 hours a day, 7 days a week.

What is Extra Help?

If you have a limited income, you may be able to get Extra Help from Medicare to pay for your prescription drug costs. If you qualify, Medicare would pay for 75 percent or more of your:

- Monthly prescription drug payments
- Annual deductibles
- Coinsurance

Many people qualify and don't know it. There's no penalty for applying. And, with Extra Help you won't have a coverage gap or a Late Enrollment Penalty (LEP).

For more information call Social Security toll-free at 1-800-772-1213, TTY 1-800-325-0778 or visit www.socialsecurity.gov/prescriptionhelp. You can also call your local Social Security office.

If you qualify for Extra Help, you may change plans once per quarter for the first 9 months of the year. If you lose Extra Help, you can change plans up to 3 months after you lost it or after you're notified that you no longer qualify (whichever is later).

[What if I have questions about the form?](#)

Please call us at the number on the back of your member ID card.

Sincerely,

The UnitedHealthcare Team

Please fill out and carefully read all information below before signing and dating this disenrollment form.

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

The plan will send me a letter with the date my plan coverage ends after they get this form. I understand that until the date my coverage ends, I must continue to fill my prescriptions at plan network pharmacies to get coverage for my prescription drugs, except in an emergency situation. I understand that there are limited times in which I'll be able to join other Medicare plans, unless I qualify for an exception under certain special circumstances.

I understand that I'm disenrolling from my Medicare Prescription Drug plan and if I don't have other coverage as good as Medicare, I may have to pay a Late Enrollment Penalty (LEP) for this coverage in the future. I understand that I'm responsible for any and all monthly payments while my Medicare Prescription Drug plan is active.

Last Name: _____ First Name: _____

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

Medicare Number: _____ Sex: ☐ M ☐ F

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

Normally, you may disenroll from a Medicare Prescription Drug plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to disenroll from a Medicare Prescription Drug plan outside of this period.

Please read the statements below 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 at this time.

- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare monthly payments.
- ☐ 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'm moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term facility). I moved/will move into/out of the facility on (insert date) ____/____/____.
- ☐ I'm joining a PACE (Program of All-inclusive Care for the Elderly) program on (insert date) ____/____/____.
- ☐ I'm joining employer or union coverage on (insert date) ____/____/____.
- ☐ I have or am signing up for other creditable coverage such as TRICARE or Veterans Assistance benefits. I understand this election is valid only if I'm currently enrolled in a Medicare Advantage Prescription Drug plan or Medicare Prescription Drug plan.
- ☐ I recently moved outside of the service area for my current plan.
- ☐ I'm disenrolling during the Annual Enrollment Period (request must be received between October 15 – December 7) and I understand my disenrollment date will be December 31.

If none of these statements apply to you or you're not sure, please call us toll-free at the number on the back of your member ID card.

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

Your signature*: _____ Date: _____

Email Address: _____

Member ID: _____

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 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: _____

Instead of sending a disenrollment request to UnitedHealthcare you can call Medicare at 1-800-633-4227, TTY 1-877-486-2048, 24 hours a day, 7 days a week to leave the plan by telephone.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.