Membership disenrollment form

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your effective date after we *get* this form from you.

Member information

Please **print** your name and address below:

Name _____

Address _____

City _____ State _____ Zip _____

County _____ Phone _____

Date of birth _____ Gender ❑ Male ❑ Female

Member ID number _____

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

AmeriHealth® Rx PDP will notify me of my disenrollment date after they *get* this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at AmeriHealth Rx PDP network pharmacies to *get coverage*. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for *certain* special circumstances. I understand that I am 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 for this coverage in the future.

Signature* _____ Date _____

*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 AmeriHealth Rx PDP or by Medicare

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

Name _____ Phone number _____

Address _____ Relationship to enrollee _____

AmeriHealth Rx PDP

A Medicare-Approved Prescription Drug Plan

Benefits underwritten by QCC Insurance Company

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