AmeriHealth 65® HMO

A Medicare Advantage Plan from AmeriHealth HMO, Inc.

Disenrollment Form

If you request disenrollment, you must continue to get all medical care from AmeriHealth 65® NJ HMO until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of AmeriHealth 65 NJ HMO's network. We will notify you of your effective date after we get this form from you.

Last name: First Name: Middle Initial		❒ Mr. ❒ Mrs. ❒ Miss. ❒ Ms.
Medicare #		
Birth Date:	Sex: ❒ M ❒ F	Home Phone Number: ( )

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 AmeriHealth 65 NJ HMO 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 by AmeriHealth 65 NJ HMO or by Medicare.

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

Name: _____

Address: _____

_____

Phone Number: (_____) _____ – _____

Relationship to Enrollee: _____

Y0041_ H3156_AH12_668 CMS Approved 10/07/2011

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Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment 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 of this period.

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 for an Election Period.

❒ **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) _____.**

❒ **I am joining employer or union coverage on (insert date) _____.**

If none of these statements applies to you or you're not sure, please contact AmeriHealth 65 NJ HMO at 1-800-645-3965 (TTY/TDD users should call 1-888-857-4816) to see if you are eligible to disenroll. We are open seven days a week, 8 a.m. to 8 p.m. (October 15th to February 14th); Monday to Friday, 8 a.m. to 8 p.m. (February 15th to October 14th).

Benefits underwritten or administered by AmeriHealth HMO, Inc.

AH3820 (9/11)
07741 2011-0322 (10/11)