SelectOption® PDP

A Medicare Prescription Drug Plan from Independence Blue Cross

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.

Instead of sending a disenrollment request to Select Option PDP you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

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

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

Select Option 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 Select Option 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 Medicare.

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

Name: _____

Address: _____

_____

Phone Number: (_____) _____ – _____

Relationship to Enrollee: _____

SelectOption® PDP

A Medicare Prescription Drug Plan from Independence Blue Cross

Disenrollment Form

Typically, 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 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 Select Option PDP at 1-888-678-7009 (TTY/TDD users should call 1-888-457-3002) 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).

SO3828 (9/11)
10505 2011-0322 (10/11)