MEDICARE ADVANTAGE OR PRESCRIPTION DRUG PLAN DISENROLLMENT FORM

UBEN 101 (R10/16) University of California Human Resources

If you are the retiree, survivor or disabled member in a UC medical plan and either you or your covered family member(s) is in Medicare, this form needs to be completed when you:

- Disenroll/cancel a Medicare family member from your plan
- Suspend your medical plan which covers a Medicare member or
- Disenroll from any Medicare plan and enroll in UC Medicare PPO without Prescription Drugs

Return this completed form to the Medicare medical plan you are leaving and make a copy for your records. Your former medical plan will need to receive this form before the effective date requested. See page 2 for plan addresses.

Disenrollment for yourself and/or your family members will be effective the last day of the month in which your medical plan receives this completed and signed form, or the date you are requesting below, whichever is later.

The following are Medicare Advantage Plans: Health Net/Seniority Plus and Kaiser Permanente—California/Senior Advantage.

The following are Prescription Drug Plans: UC Medicare PPO and UC High Option Supplement to Medicare.

RETIREE/SURVIVOR/DISABLED MEMBER INFORMATION

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER

ADDRESS (Street, City, State, ZIP)

TELEPHONE ( )	SEX	DATE OF BIRTH	IF KAISER MEMBER, LIST MEDICAL RECORD NUMBER

REASON FOR DISENROLLMENT

☐ Open Enrollment Change
Effective date will be:
12 | 31 | _____
MO DAY YEAR

☐ Out-of-Area Move
Effective date requested:
_____ | _____ | _____
MO DAY YEAR

☐ Other_____
Effective date requested:
_____ | _____ | _____
MO DAY YEAR

I, _____ request disenrollment in _____
RETIREE FIRST NAME LAST NAME CURRENT MEDICAL PLAN

for myself and/or my enrolled family members listed below. If any of my family members are in Medicare, they must also sign this form in order for the disenrollment to be effective for them. I understand that if I am disenrolling from Kaiser or Health Net, the plan must receive my completed and signed form prior to the disenrollment effective date I have requested. I understand that if I am disenrolling from UC Medicare PPO or High Option, UC must receive my completed and signed form prior to the disenrollment effective date I have requested. I further understand that medical services must be received from the plan in which I am currently enrolled until the disenrollment effective date.

Please disenroll the following Medicare family members who are enrolled in the medical plan listed above:

NAME (Last, First, Middle Initial)	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY/ID NUMBER
NAME (Last, First, Middle Initial)	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY/ID NUMBER
NAME (Last, First, Middle Initial)	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY/ID NUMBER
NAME (Last, First, Middle Initial)	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY/ID NUMBER

REQUIRED SIGNATURES

RETIREE/SURVIVOR/DISABLED MEMBER SIGNATURE	DATE
ENROLLED SPOUSE SIGNATURE **(Required if spouse/domestic partner is eligible for Medicare)**	DATE
ENROLLED FAMILY MEMBER SIGNATURE **(Required if family member is eligible for Medicare)**	DATE

SEE PAGE 2 FOR ADDRESSES AND PRIVACY NOTIFICATIONS

If disenrolling from Kaiser or Health Net, mail this disenrollment form to the plan from which you are disenrolling. (No fax available for Health Net or Kaiser.)

Health Net/Seniority Plus
Attn: Enrollment Services
P.O. Box 10420
Van Nuys, CA 91499-6208

Kaiser Permanente
Attn: CSC AAR for UC, Special Accounts
3840 Murphy Canyon Road
San Diego, CA 92123-9851

If disenrolling from UC Medicare PPO or High Option, mail or fax this disenrollment form to UC.

University of California
RASC
P.O. Box 24570
Oakland, CA 94623-1570

Fax: 510-465-9037

If you have a question about the form, please contact the plan from which you are disenrolling or the UC Retirement Administration Service Center (RASC) (800-888-8267).

PRIVACY ACT STATEMENT

Section 9312(h) of the Omnibus Reconciliation Act of 1986 authorizes collection of this information. The primary use of this information is to enable Social Security personnel to update your Medicare record in order to disenroll you from your HMO/CMP. Additional disclosures of the information may be to providers and suppliers of services, directly or dealing through Fiscal Intermediaries or Carriers, for administration of Title XVIII.

Furnishing the information on this form is voluntary, but failure to do so may result in disapproval of your disenrollment request.