Group MedicareBlue Rx
P.O. Box 3178
Scranton, PA 18505
YourMedicareSolutions.com

Disenrollment Form

Disenrollment Instructions:

If you wish to disenroll from Group MedicareBlue Rx, please carefully read and complete all sections on this form. Notify your benefits administrator, employer group or union contact of your intent to disenroll before signing and dating the form. Mail completed form to Group MedicareBlue Rx at P.O. Box 3178, Scranton, PA 18505. For information about disenrolling, call 1-877-838-3827, 8:00 a.m. to 8:00 p.m., daily, Central and Mountain Times. TTY users should call 711. For information about plans in your area, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Member Information *(Please print your name and address below):*

Group Name: ____________________________________ Group Number: ________________
Name: ____
Street Address: ____
City: ____________________________________ State: ___________ Zip: ______________
County: __________________________________ Home Phone: _________________________
Date of Birth: _____________________________
<PDP Name> ID # ___________________ Medicare Number: _____________________

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

Group MedicareBlue Rx 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 Group MedicareBlue Rx 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.

Requested disenrollment date: _________________________________

Member 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 Group MedicareBlue Rx or by Medicare.**

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

Authorized Representative Signature*: __________________________Date: ____________________

Authorized Representative Name (Print): ______________________ Phone No.: _________________

Authorized Representative Address: ____

Relationship to Member____

Group MedicareBlue℠ Rx (PDP) is a Medicare-approved Part D sponsor. Enrollment in Group MedicareBlue Rx depends on the renewal of the plan sponsor's contract with Medicare.

Coverage is available to members of an employer or union group and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*

*Independent licensees of the Blue Cross and Blue Shield Association.