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 have received this form from you.

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:

Simply Prescriptions[sm] will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Simply Prescriptions network pharmacies in order to receive my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare prescription drug plans, unless I qualify for a special circumstance. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not 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 Simply Prescriptions or by Medicare.

If you are the authorized representative, you must provide the following information:
Name : _________________________
Address: ____
Phone Number: (___) ____- _____
Relationship to Enrollee ___________________