simply Prescriptions

P.O. Box 211316
Eagan, MN 55121

For Internal Use

Please fill out and carefully read all information below before signing and dating this disenrollment form.

To terminate your policy, please fax this completed form to 716-857-6160 or mail to the address listed below.

Medicare Enrollment
P.O. Box 211316
Eagan, MN 55121

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

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

Simply Prescriptions 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.

I understand that I am disenrolling from my **Medicare Prescription Drug Plan as of:** _____.

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 Simply Prescriptions or by Medicare.

Requests must be received by the plan prior to the requested termination date. Upon processing of the request, you will receive a confirmation of disenrollment letter which includes your termination date.

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

Name: _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee:_____

If you request disenrollment, you must continue to get all prescriptions from Simply Prescriptions until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services out of Simply Prescriptions network. We will notify you of your effective date after we get this form from you. Disenrolling from your Simply Prescriptions plan does not automatically disenroll you from any stand-alone Medicare Supplement Plan that you may be currently enrolled in.

If you are disenrolling from your Medicare Advantage Plan with the intention of joining another Medicare Advantage Plan, please be advised of the following:

Typically, you may enroll in a Medicare Advantage Plan during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to enroll in 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 you are eligible for an Election Period.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I am moving into, live in, or recently moved out of 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) _____.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) _____ .

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

If you need additional information you can contact our Customer Service Department at 1-877-883-9577 (TTY: 1-800-662-1220). Our office hours are Monday through Friday, 8:00am to 8:00pm; or if you are calling from October 1-March 31, representatives are available to assist you 7 days a week from 8:00am to 8:00pm.