KAISER PERMANENTE®
Senior Advantage

SENIOR ADVANTAGE DISENROLLMENT FORM

This form is to be completed for each member of your family who wishes to discontinue membership in Kaiser Permanente's Senior Advantage Program. If you have any questions please call your local Kaiser Permanente Health Plan Member Services Department. Please return this form to the address below.

NOTE: If you want to join another HMO immediately following termination from Senior Advantage, you do not need to complete this form. Once you enroll in another Medicare + Choice contracting HMO, your current membership in Senior Advantage will be terminated automatically.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK

KAISER MEDICAL RECORD NO.	LAST NAME	FIRST NAME	MI
MEDICARE CLAIM NO.	STREET ADDRESS		
TELEPHONE NUMBER ( )	CITY	STATE	ZIP

PLEASE READ AND FILL IN YOUR REQUESTED DATE OF DISENROLLMENT

For Individual Plan members only: I understand that my disenrollment from Senior Advantage terminates all coverage through Kaiser Permanente effective the date of disenrollment.

For Group members only: I understand that my disenrollment from Senior Advantage may affect my employer group coverage, and I must contact my Group Benefits Office to complete the termination process.

For all members: I understand that I must continue to use Kaiser Permanente for all my health care, except for emergencies, out of area urgent and dialysis care, and authorized referrals, until the effective date of disenrollment.

Disenrollment effective dates are determined by the date the Health Plan receives your disenrollment request. For disenrollment requests received by the 10th of the month, the Senior Advantage disenrollment effective date will be the first of the following month. For disenrollment requests received after the 10th of the month, the Senior Advantage disenrollment effective date will be the 1st of the second month following receipt. If you are requesting a later date of disenrollment, please indicate that date in the space provided below. The date you request must be for the first day of the month for a month in the future and is subject to Health Care Financing Administration rules.

Note to beneficiary: If this is the first time you have ever enrolled in a Medicare + Choice plan, and if you are disenrolling from Senior Advantage within 12 months of your effective date of enrollment, then you may be guaranteed issuance of certain Medigap coverage. You will have 63 days from the date of disenrollment to enroll in a Medigap plan. You may contact your State Insurance Department or Insurance Counseling Agency to get more information about the availability of Medigap insurance in your State.

MY REQUESTED DATE OF DISENROLLMENT _____/_____/_____.

PLEASE SIGN HERE (Your signature, or signature of guardian or conservator)

Signature:_____ Date:_____

*Representative Signature:_____ Relationship:_____

*If this is being submitted by a guardian or conservator, please attach legal document establishing guardianship.

Return the white signed form to: Kaiser Permanente, P.O. Box 232400, San Diego, California 92193-2400