Disenrollment Form

Each member requesting to be disenrolled must complete their own form.

If you request disenrollment, you must continue to get all medical care from Health Net Seniority Plus Employer (HMO) until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Health Net Seniority Plus Employer (HMO)'s network. We will notify you of your effective date after we get this form from you.

If you have any questions, call Health Net Seniority Plus Employer (HMO) at 1-800-275-4737 (TTY: 711). We are available from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

YOU MAY TYPE TO COMPLETE THIS FORM. YOU MAY ALSO PRINT IT AND FILL IT OUT, IN WHICH CASE PLEASE PRINT YOUR RESPONSES USING BLACK OR BLUE INK. FILL CHECK BOXES IN WITH AN "X".

Last Name _____ First Name _____ MI__ ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Health Net Seniority Plus Employer (HMO) Subscriber ID Number _____

Medicare Number _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Home Phone Number _____ Mobile Phone Number _____

Permanent Residence Street Address (P.O. Box is not allowed) _____

City _____ State _____ Zip Code _____

Mailing Address if different from permanent residence (P.O. Box is allowed) _____

City _____ State _____ Zip Code _____

Email Address _____

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand that Medicare will cancel my current membership with Health Net Seniority Plus Employer (HMO) on the effective date of the new enrollment. I understand that I may not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium, due to a late enrollment penalty, for this coverage.

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I understand that my signature (or the signature of the person I have authorized to make decisions on my behalf) on this form means I have read and understand the contents of this form. If signed by an authorized representative, this signature certifies that: this person is authorized under State law to complete this disenrollment, and documentation of this authority is available upon request.

Signature*: _____ Today's 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 Health Net Seniority Plus Employer (HMO) or by Medicare.

If you are the authorized representative, you must sign above and provide the following:

Name: _____ Phone Number: _____

Address: _____Relationship to the Enrollee: _____

Typically, you may disenroll from a Medicare Advantage Plan only during the annual enrollment period which takes place 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 which may allow you to disenroll outside of this period. If you have questions about the times you may disenroll, please call Member Services for assistance.

☑ PLEASE SELECT THE DISENROLLMENT REASON THAT APPLIES TO YOU

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, to the best of your knowledge, you are eligible for an Election Period.

☐ I recently had a change in my Medicaid (newly qualified for, had a change in level of assistance, or lost eligibility for Medicaid) on _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly qualified for, had a change in level of assistance, or lost eligibility for Extra Help) on _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on _____.

☐ I am joining a PACE program on _____.

☐ I am joining employer group or union coverage on _____. I am requesting a disenrollment date of _____ with the understanding that this is subject to CMS approval.

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

If none of these statements applies to you or you're not sure, please contact Health Net Seniority Plus Employer (HMO) at 1-800-275-4737 (TTY: 711), to see if you are eligible to disenroll. We are open from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

☑ PLEASE SELECT THE REASON WHY YOU ARE LEAVING.

- ☐ PCP not in network
- ☐ Specialist not in network
- ☐ Copays are too high
- ☐ Can't get access to a service
- ☐ Premium is too high
- ☐ Was not aware I was enrolling in this plan

Other _____

You may email or return your completed form to:

MedicareDisenrollments@centene.com

Health Net of California
P.O. Box 10420
Van Nuys, CA 91410
Fax: **1-844-222-3180**

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para obtener un intérprete, llámenos al **1-800-275-4737** (TTY: **711**). Alguien que habla español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费翻译服务，以便回答您可能对我们的健康或药物计划提出的任何问题。如需翻译，请拨打电话 **1-800-275-4737**（TTY：**711**）。会说汉语普通话的人员可为您提供帮助。此项服务免费。

Chinese Cantonese: 我們提供免費口譯服務，可回答您任何關於我們健康或藥物計劃的問題。若要取得口譯服務，請致電**1-800-275-4737** (TTY：**711**)。會說粵語的人員可以幫助您。此為免費服務。

Tagalog: Mayroon kaming libreng serbisyo ng tagasalin para sagutin ang anumang mga tanong na mayroon ka tungkol sa aming health o drug plan. Para kumuha ng tagasalin, tawagin lang kami sa **1-800-275-4737** (TTY: **711**). May nagsasalita ng Tagalog na puwedeng tumulong sa iyo. Ito ay libreng serbisyo.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pouvez avoir sur notre régime de santé ou de médicaments. Pour entrer en contact avec un interprète, il suffit de nous appeler au **1-800-275-4737** (TTY : **711**). Une personne qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời mọi câu hỏi quý vị có thể có về chương trình thuốc hoặc chương trình sức khỏe của chúng tôi. Để yêu cầu thông dịch viên, chỉ cần gọi cho chúng tôi theo số **1-800-275-4737** (TTY: **711**). Nhân viên nói tiếng Việt sẽ hỗ trợ quý vị. Dịch vụ này được miễn phí.

German: Unser kostenloser Dolmetscherdienst beantwortet mögliche Fragen zu Ihrem Gesundheits- oder Medikamentenplan. Wenn Sie einen Dolmetscher benötigen, rufen Sie uns gerne unter der folgenden Rufnummer an: **1-800-275-4737** (TTY: **711**). Sie erhalten Hilfe in deutscher Sprache. Dieser Service ist für Sie kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우, **1-800-275-4737**(TTY: **711**)번으로 당사에 문의해 주십시오. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, для вас предусмотрены бесплатные услуги переводчика. Чтобы воспользоваться услугами переводчика, просто позвоните нам по номеру **1-800-275-4737** (TTY: **711**). Вам поможет сотрудник, владеющий русским языком. Эта услуга предоставляется бесплатно.

Arabic: نوفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-800-275-4737** (TTY: **711**). يمكن أن يساعدك شخص يتحدث العربية وهذه الخدمة مجانية.

Hindi: हमारे पास अपने हेल्थ या ड्रग प्लान को लेकर संभवतः आपके मन में उठने वाले सवालों के जवाब देने के लिए मुफ़्त में दुभाषिया सेवाएं हैं. दुभाषिया पाने के लिए, बस **1-800-275-4737** (TTY: **711**) पर हमें कॉल करें. हिंदी जानने वाला कोई व्यक्ति आपकी मदद करेगा. यह सेवा मुफ़्त में है.

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il numero **1-800-275-4737** (TTY: **711**). Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número **1-800-275-4737** (TTY: **711**). Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-275-4737** (TTY: **711**). Yon moun ki pale Kreyòl-Franse ka ede w. Sa a se yon sèvis gratis.

Polish: Dysponujemy bezpłatnymi usługami tłumaczeniowymi w celu odpowiedzi na dowolne pytania dotyczące naszych planów zdrowotnych i lekowych. Aby uzyskać pomoc tłumacza, zadzwoń pod numer **1-800-275-4737** (TTY: **711**). Osoba mówiąca po polsku może Ci pomóc. Ta usługa jest bezpłatna.

Japanese: 無料の通訳サービスを利用して、健康や医薬品に関するご質問にお答えします。通訳をご希望の場合は、**1-800-275-4737**（TTY: **711**）までお電話ください。日本語話者がお手伝いいたします。このサービスは無料です。