BlueCross BlueShield Kansas
P.O. Box 211355
Eagan, MN 55121

Request for Disenrollment Form

If you request disenrollment, you must continue to get all medical care from Blue Cross and Blue Shield of Kansas until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Blue Cross and Blue Shield of Kansas network. We will notify you of your effective date after we get this form from you.

Last name: First Name: Middle Initial	☐ Mr. ☐ Mrs ☐ Miss ☐ Ms.
Medicare Number:	

Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )

Disenrollment reason (please check appropriate box):	
☐ 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 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 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 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 joining a PACE program on (insert date)
☐ I am moving into, live in, or recently moved out of a 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)	Other:

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 Medicare will cancel my current membership in Blue Cross and Blue Shield of Kansas on the effective date of that new enrollment. I understand that I might 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 for this coverage.

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 Blue Cross and Blue Shield of Kansas or by Medicare.

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

Name: _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee: _____