P.O. Box 240
Columbia, TN 38402

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 get this form from you.

Instead of sending a disenrollment request to Members Health Insurance Company you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

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:

Members Health Insurance Company will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Members Health Insurance Company network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I don't 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 Medicare.

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

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