[Ex 10]

DISENROLLMENT FORM

Please carefully read and complete the following information before you sign and date this form.

- If you request disenrollment, you must continue to use your Humana Medicare coverage for all medical care until your disenrollment date.
- By disenrolling from your Humana Medicare Advantage plan, your Supplemental Benefits, if applicable, will automatically be discontinued as well.
- Contact us to verify your disenrollment before you seek medical services.
- We will notify you of your plan end date once this form has been processed.

I, the undersigned, request disenrollment from membership in the below-indicated Humana plan and agree to the following:

- If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare my current membership in [Humana Medicare Advantage] plan will end on the effective date of the 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 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.

Humana Member ID: H_____

Plan Type: Please select the plan(s) you wish to disenroll from

□ Medicare Advantage (MA)	□ Prescription Drug Plan (PDP)
□ Medicare Advantage with Prescription Drug (MAPD)	□ Optional Supplemental Benefits (OSB)

Member Name: _____
(Please Print) First Middle Last

Your Signature*: _____ Date: _____

Your Phone Number: (include area code)_____

Witness (if required):_____Date:_____
*If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this disenrollment and that documentation of this authority is available upon request by the plan or by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid programs.

If you are the authorized representative, you must provide the following information or the disenrollment request may not be processed.

Name: _____ Relationship to member:_____
Address: _____

Phone: _____

[Please return this form signed and completed to:]

[Humana]
Attn: Disenrollment Department
[P.O. Box 14168]
[Lexington, KY 40512-4168]
Fax: 1-800-633-8188

Humana is a Medicare Advantage organization with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.