

DISENROLLMENT FORM

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

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

- I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Humana 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.

Humana Member ID: H _____

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

<input type="checkbox"/> Medicare Advantage (MA)	<input type="checkbox"/> Prescription Drug Plan (PDP)
<input type="checkbox"/> Medicare Advantage with Prescription Drug (MAPD)	<input type="checkbox"/> 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: _____

Note: We will notify you of your plan end date after we get this form from you.

[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 stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.