SUMMIT HEALTH

Summit Health Medicare Advantage

Disenrollment form

If you request disenrollment, you must continue to get all medical care from Summit Health Medicare Advantage until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of the Summit Health Medicare Advantage network. We will notify you of your effective date after we get this form from you.

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.
Medicare number		Disenrollment from: ☐ Medicare Advantage ☐ Extra Care	
Birth date (mm/dd/yyyy) _____ / _____ / _____	Sex ☐ M ☐ F	Home phone number (_____) _____	

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 Summit Health Medicare Advantage 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* X	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 Summit Health Medicare Advantage or by Medicare.

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

Name	
Address	Phone number (_____) _____
Relationship to Enrollee	

Summit Health Plan, Inc.
Attn: Medicare Membership Accounting
601 SW 2nd Ave Portland, OR 97204-9748
1-844-827-2355 • TTY: 711 • Fax: 833-949-1891