



# MEDICARE RISK DISENROLLMENT REQUEST

## SISC GROUP PLAN

PLEASE PRINT IN INK

MEMBER NAME LAST	FIRST	MI.	MEMBER I.D.	
ADDRESS	CITY	STATE	ZIP	COUNTY
TELEPHONE #	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH		
MEDICARE #	GROUP #	SOCIAL SECURITY #		

PLEASE READ CAREFULLY AND COMPLETE THE INFORMATION BELOW BEFORE SIGNING AND DATING THE DISENROLLMENT FORM.

### CURRENT HEALTH PLAN

( ) Health Net Seniority Plus      ( ) Kaiser Senior Advantage      ( ) PacifiCare Secure Horizons

( ) I WISH TO RETURN TO MEDICARE COVERAGE.  
 ( ) I WISH TO DISENROLL FROM THE ABOVE HMO PLAN AND ENROLL WITH THE PLAN LISTED BELOW.

### NEW HEALTH PLAN

( ) Health Net Seniority Plus      ( ) Kaiser Senior Advantage      ( ) PacifiCare Secure Horizons

( ) Other \_\_\_\_\_ Effective Date \_\_\_\_\_

**Members who have requested disenrollment must continue to receive all medical care (except for emergencies, out-of-area urgent care, or authorized referrals) from their HMO plan until the effective date of the disenrollment.**

Requested disenrollment date: \_\_\_\_\_

Medicare benefits may only be restored on the first of the month. The process to restore your Medicare benefits requires a minimum of thirty (30) days; therefore, this disenrollment form must be received by SISC at least thirty (30) days prior to the date you need your Medicare benefits restored.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SISC USE ONLY

Date received: \_\_\_\_\_ Date submitted to Health Plan: \_\_\_\_\_

Processed by: \_\_\_\_\_