MASSACHUSETTS

Blue MedicareRx℠

Disenrollment Form

If you request disenrollment, you must continue to fill your prescriptions from Blue MedicareRx network pharmacies until the effective date of disenrollment. We will notify you of your effective date after we have received this form.

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
_____	_____	_____	

Member ID#:	Birth Date:	Sex:	Home Phone Number:
_____	_____	☐ M ☐ F	(___) ____- _____

By completing this disenrollment request, I agree to the following:
Blue MedicareRx 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 Blue MedicareRx 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.

Your 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 Blue Cross Blue Shield of Massachusetts or by Medicare.

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

Name:	Address:
_____	_____

Phone Number: (___) ____- _____ Relationship to Enrollee: _____

Please mail this form to:
Blue Cross Blue Shield of Massachusetts, P.O. Box 55035, Boston, MA 02215-3326

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