# CDPHP Group Medicare
## Member Disenrollment Form

Today's Date: _____

Company Name: _____ Contact Person: _____

Title: _____ Telephone: (____) ____ - _____ Fax: (____) ____ - _____

Group Number: _____ Requested Term Date: ____ /____ /_____

Member First and Last Name: _____

Member ID#: _____ DOB: ____ /____ /_____

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**DISENROLLMENT REASON/QUALIFYING EVENT**

*The full guidance on Disenrollment rules can be found in the Medicare Managed Care Manual (MMCM) in Chapter 2 at https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf.*

◯ **Voluntary disenrollment** *(member initiated) (MMCM Ch 2, Section 50.1)*

Member signature *(if a voluntary termination)*: _____

Please terminate my coverage effective*: ____ /____ /_____ Today's date: ____ /____ /_____

*(*Please include the member's written request or have the member sign above. This date must be end of current month, and not retroactive per CMS guidelines)*

◯ **Moving Out of the CDPHP service area** *(MMCM Ch 2, Section 50.2.1.1)*

Updated Address: _____

Date of Move*: ____ /____ /_____

*(*Effective the first day of the calendar month after the date the member begins residing outside of the MA plan's service area AND after the member or his or her legal representative notifies the organization that he or she has moved and no longer resides in the plan service area.)*

◯ **Involuntary Disenrollment** *(MMCM Ch 2, Section 50.7)*

- Member must be notified not less than 21 calendar days prior to the effective date of termination that the employer intends to disenroll them from the Medicare Advantage plan.
- The letter must include an explanation of how to contact Medicare for information about other Medicare Advantage plan options that may be available.
- If the plan includes prescription drug coverage, the member must be advised that disenrollment means they will no longer have Medicare Part D, and the potential of owing a late enrollment penalty if they do not enroll in other coverage within 63 days.
- The disenrollment request to CDPHP must include the written notification sent to the member if less than 30 days prior to the effective date of the termination.

◯ **Death** *(MMCM Ch 2, Section 50.2.3)*

- Please note that we are not allowed to relay this information to CMS. CMS must receive this information from SSA, and it is the survivor's responsibility to notify SSA.

◯ **Retroactive Disenrollment Requests** *(MMCM Ch 2, Section 60.6, 60.6.1 and 60.6.2)*

- Please include all documentation provided by the member requesting disenrollment including the date the documentation was submitted (i.e.: date stamp received on the documentation). CMS has up to 35 days to make a determination on retroactive disenrollment requests.

Please fax the completed form to (518) 641-4606, or email to medicareeligibility@cdphp.com.