Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits, Inc.®
6 Wellness Way, Latham, NY 12110
1-888-248-6522 or TTY:711

CDPHP® Medicare Plan Disenrollment Form

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

Date _____ CDPHP Medicare Plan ID # _____

Last Name, First Name, Middle Initial _____

Street Address _____ Gender: ◯ M ◯ F

City, State, Zip Code _____ Telephone Number _____

Reason for Disenrollment: _____

_____

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 CDPHP 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* _____ **Date Signed** _____

*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 CDPHP or by Medicare.
If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Telephone Number(s): _____

Relationship to Enrollee: _____