Each individual disenrolling will need to complete his/her own form. If you have any questions, please call Kaiser Permanente at 1-800-443-0815 (TTY 711), seven days a week, 8 a.m. to 8 p.m.

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente, until the effective date of disenrollment. Please refer to your Evidence of Coverage for more details. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente’s network. We will notify you of your effective date of disenrollment after we get this form from you.

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Disenrollment Period from January 1 through February 14 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.

PLEASE SELECT A DISENROLLMENT REASON BELOW
Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
☐ I get extra help paying for Medicare prescription drug coverage.
☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) ____________.
☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ____________.
☐ I am joining a PACE program on (insert date) ____________.
☐ I am joining employer or union coverage on (insert date) ____________. I am requesting a disenrollment date of (insert date) ____________ with the understanding that this must be approved by CMS.
☐ I have moved out of the Kaiser Permanente service area on (insert date) ____________. I am requesting a disenrollment date of ____________ with the understanding that this must be approved by CMS.
☐ I have joined another plan with creditable prescription drug coverage (coverage as good as Medicare’s) on (insert date) ____________.
☐ My employer group coverage has ended or will transfer to a new health care plan on (insert date) ____________. I am requesting a disenrollment date of ____________ with the understanding that this must be approved by CMS.
☐ Other – Please explain _____________________________________________________________.
Please carefully read the following information before signing and dating this disenrollment form.

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente 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.

If you have selected to have Medicare prescription drug coverage from Kaiser Permanente, by disenrolling from Kaiser Permanente you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of the year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area you can call 1-800-MÉDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Senior Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Senior Advantage for Federal employees.

Your signature* ___________________________ 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 Kaiser Permanente or by Medicare.

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

Name ____________________________________________
Address __________________________________________
Phone ____________________________________________
Relationship to enrollee ____________________________

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This information is available in a different format by calling the number listed in the first paragraph.

Return the top, signed white copy to:
Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193

If required, send the middle copy to your employer group or union/trust fund. Keep the bottom copy for your records.
Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-443-0815** (TTY 711), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at [http://www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).
Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-443-0815 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-443-0815 (TTY: 711).

Chinese
注意:如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-443-0815（TTY：711）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-443-0815 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-443-0815 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-443-0815 (TTY: 711)번으로 전화해 주십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-443-0815 (TTY (հեռախոսի) 711):

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-443-0815 (телетайп: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-443-0815（TTY:711）まで、お電話にてご連絡ください。

Punjabi
ਪਹਾੜ ਦੀ ਖਿਲਾਤ ਨੇ ਦੁਨੀਅ ਭਾਸ਼ਾ ਬੈਬਲ ਵੇਨ ਲੰਬੰਦ ਮੰਜਿਤ ਮੇਡਾ ਉੱਤਰਾਂ ਦੀ ਮੁਹਤਦੀ ਵਿਚਕਾਰਦੀ ਪਹਾੜ ਦੀ ਖਿਲਾਤ ਨੇ। 1-800-443-0815 (TTY: 711) ਉੱਤਰਾਂ ਵਾਲੇ।
Cambodian
ប្រយោគ: ប្រឈមពិពារសិក្រមពីការសំណើអំពីនេះ អំពីប្រការីសិក្រម និងអំពីការសំណាង់ពីការសិក្រមប្រការី ដែលមានប្រយោគ 1-800-443-0815 (TTY: 711)។

Hmong

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-443-0815 (TTY: 711) पर कॉल करें।

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-443-0815 (TTY: 711).

Farsi
توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌شود. تماس با 1-800-443-0815 (TTY: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 5180-344-008-1 (رقم هاتف الصم والبكم: 117).