



## DIENROLLMENT REQUEST FORM

***NOTE TO BENEFICIARY:*** *If you have already joined or intend to enroll in a new Medicare Managed care plan or a Medicare Advantage plan, you do not have to complete this form because once you enrolled in another managed care plan you will automatically be disenrolled from PHC.*

Date: \_\_\_\_\_

**Please Print in Ink**

Member's Name \_\_\_\_\_  
                                    First                                    Middle                                    Last

Street Address \_\_\_\_\_

Mailing Address \_\_\_\_\_  
(if different from street)

                                    \_\_\_\_\_  
                                    City                                    State                                    Zip Code                                    County

Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_                      Date of Birth \_\_\_\_\_                      Medicare # \_\_\_\_\_

Reason for Disenrolling (Optional) \_\_\_\_\_

### DIENROLLMENT RESPONSIBILITIES

**Please carefully read and complete the following information before signing and dating this disenrollment form:**

On the effective date of enrollment in another Medicare managed care or Medicare Advantage plan, Medicare will automatically cancel your current membership in Physicians Health Choice.

If you request disenrollment, you must continue to receive all medical care from Physicians Health Choice until the effective date of disenrollment. To avoid any unanticipated expenses, you may want to contact us to verify your disenrollment before you seek medical services outside of the Physicians Health Choice network. We will notify you of your effective date after we have received this form from you.

Requested Disenrollment Date \_\_\_\_\_

Member (Beneficiary) Signature \_\_\_\_\_ Date \_\_\_\_\_

If beneficiary is unable to sign this request, legal guardian may sign below. If legal guardian signs on behalf of beneficiary, a copy of the legal documentation authorizing legal guardian must accompany this form.

Beneficiary Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_