Kaiser Permanente Senior Advantage (HMO) or Kaiser Permanente Senior Advantage Medicare Medi-Cal (HMO SNP) Plan

**DISENROLLMENT FORM**

Northern California or Southern California Region

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.

**PLEASE TYPE OR PRINT USING BLACK OR BLUE INK**

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<th>KAISER PERMANENTE MEDICAL/HEALTH RECORD #</th>
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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 _____________________________________________________________________________.

Y0043_N00007140 approved
SKU 60743710 CA 01/2018
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-MEDICARE (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, 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.
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 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 (հեռախոս)՝ 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
ਪੰਜਾਬੀ ਨੇੜ੍ਹਿ: ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤੋਂ ਵਿਸ਼ੇਸ਼ ਵਿੱਚ ਮੁਹੂਰਤ ਮੇਂ ਤੂਣ ਮੁਦਾਂ ਬਤੀਆ ਹੋ ਸਕੇ। 1-800-443-0815 (TTY: 711) ਲੈ ਬਿਨਾ ਬਲੇ।

H0524_H6050_H6052_17MLI accepted
60503713 CA
Cambodian
ប្រយុទ្ធដែលប្រើប្រាស់ភាសាខ្មែរ, ស្គេចសិល្បស្សាហកំណាពែង គឺប្រើប្រាស់ប្រយុទ្ធដែលមាន ស្ថានភាពខ្ពស់បំផុត ឬមាន ១-៨០០-៤៤៣-០៨១៥ (TTY: ៧១១)។

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 می‌باشد. باشند با (111) 1-800-443-0815 تماس بگیرید.

Arabic
ملحوظة: إذا كنت تتحدث اجاف اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني. اتصل بـ 5180-344-008-1(رقم هاتف الصم والبكم: 117).