

Re: Disenrollment Form

If you request disenrollment, you must continue to get all medical care from First Choice VIP Care (HMO- SNP) until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of First Choice VIP Care network. We will notify you of your effective date after we get this form from you.

	Last name:	First Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Miss.	□ Ms.	
	Medicare #			1		-
	Birth Date:	Sex:	l l	ne Number:		
	lease carefully ro	_	ne following infor	rmation before signing a	nd dating	this
w uı di	rill cancel my curn nderstand that I m isenrolling from n	rent membership in laight not be able to e	First Choice VIP nroll in another pl ption drug coverage	licare Prescription Drug P Care on the effective dat an at this time. I also unde ge and want Medicare pres rage.	e of that nerstand tha	ew enrollment. I at if I am
Y	Your Signature*:			Date:		
si ui	gned by an authornder State law to	rized individual (as	described above), ollment and 2) do	behalf under the laws of t this signature certifies tha cumentation of this author	t: 1) this p	erson is authorized
	If you are the au	thorized representativ	ve, you must provid	e the following information	Ľ	
	Name:				_	
	Address:				_	
	Phone Number	:()				
	Relationship to	Enrollee			_	