



Disenrollment Request

Dear member:

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

Last name	First name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms.
Medicare number		Birth date	
Sex <input type="checkbox"/> M <input type="checkbox"/> F		Home phone number ()	

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 the Aetna Medicare plan 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
* 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 Aetna or by Medicare.	

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

Name	
Address	
Phone number ()	Relationship to enrollee

Attestation of Eligibility for an Election Period

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.

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.

<input type="checkbox"/>	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
<input type="checkbox"/>	I get extra help paying for Medicare prescription drug coverage.
<input type="checkbox"/>	I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
<input type="checkbox"/>	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) _____.
<input type="checkbox"/>	I am joining a PACE program on (insert date) _____.
<input type="checkbox"/>	I am joining employer or union coverage on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact our Retiree Service Center at **1-800-338-4533** (TTY users should call **711**) to see if you are eligible to disenroll. From October 1 to January 31, we're open Monday through Friday, 8 a.m. to 8 p.m. ET. From February 1 to September 30, we're open Monday through Friday, 8 a.m. to 6 p.m. ET.

Please return the completed form to the following address: Aetna Medicare PO Box 14088 Lexington, KY 40512-4088	Or fax to: 1-888-665-6296 Attn: Disenrollment
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Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number listed in this material.

ESPAÑOL (SPANISH): ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en este material.

繁體中文 (CHINESE): 請注意：如果您說中文，您可以獲得免費的語言協助服務。請造訪我們的網站 www.aetnamedicare.com 或致電本材料中所列的電話號碼。