If you request disenrollment, you must continue to get all medical care from Health Choice Pathway HMO D-SNP until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Health Choice Pathway's 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.
Member Number:		
Birth Date:	Sex: ☐M ☐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 Health Choice Pathway 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 Health Choice Pathway or by Medicare.

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

Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____