Medicare Part D Disenrollment Form

Please carefully read all the information below and completely fill out the disenrollment form. Remember to sign and date it before sending it to the NRECA Medicare Part D Prescription Drug Plan, an Employer PDP. You will be notified of your effective date after the NRECA Medicare Part D Plan receives this form.

First Name:	Middle Initial:	Last Name:
Member ID (from your Part D ID card):		HIC number (from your Medicare ID card-*optional*):
Birth Date:	Sex: ❑ M ❑ F	Home Telephone Number: ( )

Reason for disenrollment:

- ❑ Open Enrollment
- ❑ Eligible for low income subsidy
- ❑ Entering/leaving long-term care facility on this date: ___________________________
- ❑ I have other creditable coverage and want to enroll in or keep that coverage
- ❑ Moved outside the United States
- ❑ Other (please explain): ____

By completing this disenrollment request, I agree to the following:
The NRECA Medicare Part D Prescription Drug Plan, an Employer PDP, will notify me of my disenrollment date after they receive this form. I understand that in order to have prescription drug coverage, I must continue to fill my prescriptions at NRECA network pharmacies until my disenrollment is effective. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for a special circumstance. I understand that if my co-op has been paying a late enrollment penalty for Part D on my behalf, I will now be responsible for paying this penalty amount myself.

I understand that I am dropping my Medicare prescription drug plan coverage. If I do not enroll in another Medicare prescription drug plan or have creditable prescription drug coverage that is at least as good as Medicare's drug coverage, I may have to pay a late enrollment penalty, in addition to my monthly premium, for Medicare prescription drug coverage in the future, and that I may lose my NRECA medical coverage, if any.

Signature* ____ Date: ______________

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 NRECA or by Medicare.

If you are the authorized representative, you must provide the following information:
Name : ____
Address: ____
Phone Number: (_____) _______- ________ **Relationship to Enrollee** _______________________

 NRECA is a Medicare-approved Part D Plan sponsor.