

Medicare Part D Disenrollment Form



Please carefully read and fill out all information below before signing and dating this disenrollment form. We will notify you of the effective date of your disenrollment after we get this form. Instead of sending a disenrollment request to the NRECA Medicare Part D Prescription Drug Plan, an Employer PDP, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.



Member ID		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
First Name	Middle Initial	Last Name	
Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number	

Reason for disenrollment:

Open enrollment

Eligible for low income subsidy (extra help)

Entering or leaving a health care institution on this date: _____

I have other creditable coverage and want to enroll in or keep that coverage

Moved outside the United States or its territories

Other (please explain): _____

By completing this disenrollment request, I agree to the following:

The NRECA Medicare Part D Prescription Drug Plan will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at NRECA Medicare Part D Prescription Drug Plan network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare prescription drug plans, unless I qualify for a special circumstance. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not enroll in another Medicare prescription drug plan or have coverage 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. 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.

Participant Or Authorized Representative's Signature			Date	
If you are the authorized representative, by signing this form you certify that: 1) you are authorized under state law to complete this disenrollment and 2) documentation of this authority is available upon request by the NRECA Medicare Part D Prescription Drug Plan or by Medicare. Please provide the following information:				
First Name	Middle Initial	Last Name		
Address	City	State	ZIP	
Phone	Relationship To Participant			