

Disenrollment Form

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

Last name:	First Name:	Middle Initial
Member Number: (Note: may use "Member Number" instead of "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 AmeriHealth Caritas VIP Care 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 AmeriHealth Caritas VIP Care or by Medicare.

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

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

AmeriHealth Caritas VIP Care is an HMO-SNP plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-964-4433 (TTY 711)** de 8 a.m. a 8 p.m., los siete días de la semana. La llamada es gratuita.

تنويه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية لك مجانًا. يُرجى الاتصال بالرقم **1-844-964-4433 (TTY 711)**، من 8 صباحًا إلى 8 مساءً، سبعة أيام في الأسبوع. المكالمات مجانية.

You can also get this information for free in other formats, such as large print, Braille, or audio. Call **1-844-964-4433 (TTY 711)**, 8 a.m. – 8 p.m., seven days a week. The call is free.