Amerigroup
An Anthem Company

Amerivantage Select (HMO) Individual Disenrollment Form 2019

Mail the completed form to the address below:

Enrollment Processing Center
P.O. Box 659403
San Antonio, TX 78265-9714

Or fax the completed form to: 1-800-833-8554

If you request disenrollment, you must continue to get all medical care from Amerivantage Select (HMO) until the effective date of disenrollment. Contact us at **1-866-805-4589** (Customer TTY users should call **711**) to verify your disenrollment before you seek medical services outside of Amerivantage Select (HMO)'s network. We are open 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. We will notify you of your disenrollment effective date after we get this form from you.

Please contact Amerivantage Select (HMO) if you need information in another language or format (Large Print, Audio or Braille).

Last name	First name		Middle Initial
Member Number			
Birth date	Gender ☐ M ☐ F	Home phone number	
Permanent residence street address	City	State	ZIP code

Typically, you may disenroll from a Medicare Advantage plan only during the annual election period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of these periods.

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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.

☐ It is annual election period (AEP) October 15 through December 7.

☐ It is the open enrollment period (OEP) January 1 through March 31.

☐ I have other creditable coverage (such as member of Tricare/VA or want to obtain VA benefits).

☐ I am enrolling or currently enrolled in an Employer Group Health Program (EGHP). Effective date of EGHP Plan:_____.

☐ I get extra help paying for Medicare prescription drug coverage (Low-Income Subsidy).

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date):_____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date):_____.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date):_____.

☐ I am making a permanent move outside of the service area. Date of move:_____.

☐ I am moving into, live in, or recently moved out of a Long-Term-Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date):_____.

☐ I am joining a Program of All-Inclusive Care for the Elderly (PACE) program on (insert date):_____.

☐ I am joining employer or union coverage on (insert date) _____.

☐ I am disenrolling from Medicare Advantage during the first 12 months after my Initial Election Period when I turned 65.

☐ Other _____

_____

If none of these statements apply to you or you're not sure, please contact Amerivantage Select (HMO) at **1-866-805-4589** (TTY users should call **711**) to see if you are eligible to disenroll. We are open 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

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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 Amerivantage Select (HMO) 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.

I understand that my signature (*or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) on this disenrollment form means that I have read and understand the contents of this application. 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 Amerivantage Select (HMO) or by Medicare.

Applicant Signature or Authorized Representative as described above:* _____ Today's date:_____

*If you are the Authorized Representative, you must sign above and provide the following information:

Authorized Representative name	Phone number	Relationship to enrollee	
Street address	City	State	ZIP code

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability in our health programs and activities.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-866-805-4589 (TTY: 711).

ATENCIÓN: Si habla español, los servicios de asistencia lingüística están disponibles sin costo alguno para usted. Llame al 1-866-805-4589 (TTY: 711).

Amerigroup Texas, Inc. is an HMO plan with a Medicare contract. Enrollment in Amerigroup Texas, Inc. depends on contract renewal.