simply Prescriptions

P.O. Box 211316
Eagan, MN 55121

For Internal Use

Please fill out and carefully read all information below before signing and dating this disenrollment form.

To terminate your policy, please fax this completed form to 716-857-6160 or mail to the address listed below.

Medicare Enrollment
P.O. Box 211316
Eagan, MN 55121

Last Name: First Name: Middle Initial:		☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Member ID:	Plan Name:	
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )

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

Simply Prescriptions will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Simply Prescriptions network pharmacies in order to receive my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or 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 have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

I understand that I am disenrolling from my **Medicare Prescription Drug Plan as of:** _____.

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 Simply Prescriptions or by Medicare.

Requests must be received by the plan prior to the requested termination date. Upon processing of the request, you will receive a confirmation of disenrollment letter which includes your termination date.

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

Name: _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee:_____