Form to Request to End Plan (Disenroll) and Special Election Questionnaire
Please carefully read the below information before you complete the below 4 sections of information and sign and date this form.

- If you request to end your plan, you must continue to use your Humana Medicare coverage for all medical care until your end date.
- By ending your Humana Medicare Advantage plan, your Optional Supplemental Benefits (OSB), added to your plan, such as, dental or vision will automatically end, as well.
- Typically, you may end 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 end a Medicare Advantage plan outside of this period.
- We will notify you of your plan end date once this form has been processed. Usually Medicare plans end on the last day of the month the request is received when using a Special Election Period. During the Annual Election Period the plan will end on 12/31. You can contact us if you have questions about your plan end date before seeking medical services.

I, the undersigned, request to end membership in the below-indicated Humana plan and agree to the following:

- If I have enrolled in another Medicare Advantage or Medicare prescription drug plan, I understand my current membership in a Humana Medicare Advantage plan will end on the effective date of the 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 ending my Medicare prescription drug plan and, if I do not have other coverage as good as Medicare, I may have to pay a lifetime late enrollment penalty for prescription drug coverage in the future.

1. Member Information

First Name:	**Middle Initial:**	**Last Name:**
Member ID*: H		**Requested Plan End Date**:**
Member Phone Number: ( )		

***** Your Humana ID number appears on your Humana ID card and begins with an “H”.
****** Usually Medicare plans end on the last day of the month the request is received when using a special election period. During the Annual Election Period the plan will end on 12/31.

2. Member Signature & Authorized Representative Information

Member Signature:**	**Date:**

**If the member cannot sign, a person who is authorized to do so under state law in the state where the member lives must sign above. This signature certifies that the person who signs is authorized under state law to complete this disenrollment. It also certifies that written proof of this authority is available if the plan or the Centers for Medicare & Medicaid Services (CMS) request it. CMS is the federal agency that administers Medicare and Medicaid.

If you are the authorized representative, please complete the section below. If we don't have this information, we may not be able to process the disenrollment request.	
Name:	**Relationship to member:**
Address:	
Phone: ( )	

3. Member Plan Information and Special Election Period
Please select the plan(s) you wish to end:

☐ Medicare Advantage (MA)	☐ Optional Supplemental Benefits (OSB)
☐ Medicare Advantage with Prescription Drug (MAPD)	☐ Other:

Please read the following statements carefully and check the box or boxes if the statement(s) applies to you. By checking any or all of the following boxes that apply to you, you are certifying that, to the best of your knowledge, you are eligible for a Special Election Period.

☐ 1. I have Medicaid or Extra Help paying for my Medicare prescription drug coverage and had a change in the last 3 months? If so, when? ___/___/_____ (MM/DD/YYYY)	☐ 7. *I have Medicaid or Extra Help paying for my Medicare prescription drug coverage and have **not** had a change in the last 3 months. If so, when? ___/___/_____ (MM/DD/YYYY)
☐ 2. I live in a nursing home or other long-term care facility.	☐ 8. I am enrolled in – or I have joined – a Program of All-inclusive Care for the Elderly (PACE).
☐ 3. I lost insurance with an employer, retirement plan, union, COBRA plan or my spouse's employer, union, or COBRA plan within the past two months.	☐ 9. I am in my first year of enrollment in a MA or MAPD plan and dropped a Medicare Supplement plan to enroll into my Humana plan.
☐ 4. I plan to move into a nursing home or other long-term care facility. If so, when? ___/___/_____ (MM/DD/YYYY)	☐ 10. I was enrolled into a plan by Medicare (or my state) and want to choose a different plan. If so, when? ___/___/_____ (MM/DD/YYYY)
☐ 5. I moved from a nursing home or other long-term care facility in the past three months.	☐ 11. **I have creditable coverage through any of the groups listed below. "Creditable coverage" means a prescription plan that's at least as good as Medicare's basic prescription plan. • The Veteran's Administration • Tricare • Qualified State Pharmaceutical Program (SPAP) Plan • Indian or Tribal Insurance • Another carrier • Triple S
☐ 6. I have insurance with: my employer, retirement plan, union, Consolidated Omnibus Budget Reconciliation Act (COBRA) plan or my spouse's employer, union, or COBRA plan.	

*There are restrictions to how many times a year this special election can be used and cannot be used October 1-December 3.
**This special election can only be used if ending a Medicare Advantage plan with prescription drug coverage (MAPD).

4. Return form to Humana
Please return all pages of the signed form via mail or fax:

Mail to: Humana Attn: Medicare Disenrollment PO Box 14168 Lexington, KY 40512-4168	Or Fax to: Humana Attn: Medicare Disenrollment 1-800-633-8188