Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

If you request disenrollment, you must continue to get all medical care from Medi-Pak® Advantage (HMO) until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Medi-Pak Advantage's (HMO) network. We will notify you of your effective date after we get this form from you.

Last name:	First Name:	Middle Initial	☐ Mr. ☐ Mrs ☐ Miss ☐ Ms.
Medicare #			
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )	

Disenrollment reason (please check appropriate box):	
☐ I am moving out of the Medi-Pak Advantage (HMO) service area	☐ I am returning to my previous Medigap coverage
☐ I am joining coverage through my spouse	☐ I am returning to my employer's coverage
Other:	☐ I am joining other creditable coverage

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, I understand Medicare will cancel my current membership in Medi-Pak Advantage (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 Advantage coverage and want Medicare Advantage 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 Medi-Pak Advantage (HMO) or by Medicare.

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

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

Health Advantage is an HMO plan with a Medicare contract. Enrollment in Health Advantage depends on contract renewal. You must continue to pay your Medicare Part B premium.

Please mail disenrollment form to:

Arkansas Blue Cross Blue Shield
P.O. Box 44765
Detroit, MI 48244-0765
Fax: 1-844-601-2370

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-844-662-2276 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.