Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your effective date after we get this form from you.

Instead of sending a disenrollment request to Medi-Pak Rx (PDP) you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

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 Rx (PDP) 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

By completing this disenrollment request, I agree to the following: Medi-Pak Rx (PDP) will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Medi-Pak Rx (PDP) network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I don't have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

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 Rx (PDP) or by Medicare.

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

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

Arkansas Blue Cross and Blue Shield is a PDP plan with a Medicare contract. Enrollment in Arkansas Blue Cross and Blue Shield 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