2023 Health Advantage HMO Form

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

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

FIRST name	**LAST name**	**Middle Initial**

Medicare Number	**Prefix**
- -	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Birth Date (MM/DD/YYYY)	**Sex**	**Phone Number**
(/ /)	☐ M ☐ F	( ) -

Disenrollment reason (please check appropriate box):

- ☐ I am moving out of the Health Advantage (HMO) service area
- ☐ I am joining coverage through my spouse
- ☐ I am returning to my previous Medigap coverage
- ☐ I am returning to my employer's coverage
- ☐ I am joining other creditable coverage
- ☐ Other:

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage Plan, I understand Medicare will cancel my current membership in Health 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.

Signature	**Today's 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 Health Advantage (HMO) or by Medicare.

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

Name	**Relationship to enrollee**

Address	**Phone Number**
	( ) -

Please mail disenrollment form to:
Health Advantage • P.O. Box 3648 • Little Rock, AR 72203 • Fax: 1-501-301-1927

HMO Partners, Inc. (d/b/a Health Advantage) offers HMO plans with a Medicare contract. Enrollment in Health Advantage depends on contract renewal.
Si tiene problemas para obtener información de nuestro plan en un formato accesible y apropiado para usted, llame al 1-800-331-2285 para presentar un reclamo con Health Advantage (HMO).