

Request for Disenrollment Form

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

Last Name:	First Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms.
Medicare Number:			
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	

Disenrollment Reason (please check appropriate box):	
<input type="checkbox"/> I am joining employer or union coverage on (insert date)	<input type="checkbox"/> I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)
<input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)	<input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven’t had a change.
<input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)	<input type="checkbox"/> I am joining a PACE program on (insert date)
<input type="checkbox"/> I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date)	Other:

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 Prescription Drug Plan, I understand Medicare will cancel my current membership in Vermont Blue Advantage 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 prescription drug coverage and want Medicare prescription drug 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 Vermont Blue Advantage or by Medicare.

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

Name: _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____

For questions about this form, eligibility, and premium contribution questions, please contact the Vermont State Teachers' Retirement Office toll-free at 1-800-642-3191, Monday through Friday, 7:45 a.m. to 4:30 p.m., Eastern time. TTY users call 711.

Please send your completed Request of Disenrollment Form to the retirement office, by any one of these three methods:

Mail to:

Vermont State Teachers' Retirement System
Office of the State Treasurer
109 State Street, Floor 4
Montpelier, VT 05609-6200

OR

Email to: TRE.RetirementBenefitPayroll@vermont.gov

OR

Fax to: 1-802-828-5182