FREEDOM HEALTH
P.O. Box 151108, Tampa, FL 33684

Disenrollment Form and Attestation of Eligibility

Please return the completed form **via Fax: 1-888-548-0098**
OR mail to **P.O. Box 151108, Tampa, FL 33684**

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

Last name:_____ First name:_____ Middle Initial:____

Medicare Number:_____ Member ID:_____

Birth Date: M M D D Y Y Y Y Gender: ❑ M ❑ F Phone Number: (_____)_____

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment 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 disenroll from a Medicare Advantage plan outside of this period.

Attestation of Eligibility for an Election Period

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on M M D D Y Y Y Y

❑ 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 M M D D Y Y Y Y

❑ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

❑ 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 M M D D Y Y Y Y

❑ I am joining a PACE program on M M D D Y Y Y Y

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- ❑ I am joining employer or union coverage on M M D D Y Y Y Y
- ❑ I am joining or currently have other Creditable Coverage (such as TriCare or VA coverage) on M M D D Y Y Y Y
- ❑ 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 M M D D Y Y Y Y
- ❑ I was affected by a weather-related emergency, major disaster, or other emergency (as declared by the Federal Emergency Management Agency (FEMA), the state government, or the local government. One of the other statements here applied to me, but I was unable to make my disenrollment because of the natural disaster or other emergency.
- ❑ Other:_____

If none of these statements applies to you or you're not sure, please contact Freedom Health at 1-800-401-2740 (TTY users should call 711) to see if you are eligible to disenroll. From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. EST.

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 Freedom Health 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.

Enrollee Signature* _____ **Date:** M M D D Y Y Y Y

Enrollee Name:_____

*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 Freedom Health or by Medicare.

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

Name:_____

Address:_____

Phone Number: (_____)_____ **Relationship to Enrollee:**_____

Office Use Only:

Member ID: -01	**Date Received:**