Default Enrollment Opt-Out Form – DRAFT

Instructions: Please use this form if you decide you do not want to have automatic enrollment into the < Medicare Advantage D-SNP name> described in the attached letter. If you choose not to enroll in <Medicare Advantage D-SNP name>, you will be enrolled into Original Medicare and a prescription drug plan upon your Medicare start date unless you choose to enroll into a different Medicare Advantage plan.

We will send you an acknowledgement notice to confirm receipt of your decision to opt out of default enrollment.

Please send the completed form back to us in the enclosed envelope. If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Last Name:	First Name:	Middle Initial
( ) Mr ( ) Mrs ( ) Miss ( ) Ms.		
Suffix (circle as applicable) Jr. Sr. I, II, III,		
Medicare Number (Note: may use “Member Number” instead of Medicare Number)		
Birth Date:	Gender: M____ F____ X ____	
Home Phone Number: ( ) –		

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

☐ I do not wish to be enrolled into the <Medicare Advantage D-SNP plan name>. I understand that I will be enrolled into Original Medicare and a prescription drug plan upon my Medicare eligibility effective date unless I choose another Medicare Advantage D-SNP or Medicare Advantage plan.

Your Signature*: ______________________________ Date: _____________

*Or the signature of the person authorized to act on your behalf under the laws of the State of Hawaii. 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 <plan name> or by Medicare.

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

Name : ________________________

Address: ____

Phone Number: (   ) ______________________________________

Relationship to Enrollee: __________________________________