WellSense HEALTH PLAN

If you request disenrollment, you must continue to get all medical care from WellSense Senior Care Option (HMO D-SNP) until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of WellSense Senior Care Option (HMO D-SNP)'s network. We will notify you of your effective date after we get this form from you.

Last Name: First Name: Middle Initial:		**☐Mr. ☐Mrs. ☐Miss☐Ms.**
Medicare #:		
Birth Date:	**Sex:** **☐M ☐F**	**Home Phone Number:** ( )

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 WellSense Senior Care Options (HMO D-SNP) on the effective date of that new enrollment.

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 WellSense Senior Care Options (HMO D-SNP) or by Medicare.

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

Name: _____

Address: _____

Phone Number: (_____) _____-_____

Relationship to Enrollee: _____