UNITED HEALTHCARE

Disenrollment Form

You must complete this form **IF** you or your dependent(s) are disenrolling from your Plan.

Disenrollment Responsibilities:

Please read carefully and complete all information below before signing and dating this Disenrollment Form. UnitedHealthcare will notify you of your disenrollment date.

	Name	Medicare Claim Number	Member ID Number	Sex (M or F)	Birth Date
Retiree					
Spouse					
Dependent(s)					
Dependent(s)					

Street Address:	Suite/Apt. Number (If Needed):
City:	State: Zip Code:
Home Telephone: (______) _______-__________	
Requested Date of Disenrollment:	
Please Explain the Reason for Disenrollment:	

I will continue to obtain my health care coverage from my Plan until the disenrollment date.

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug plan, I understand Medicare will cancel my current membership in UnitedHealthcare Group Medicare 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.

Disenrollment from my present Plan will be effective on the first day of the month after written request (unless a later date of disenrollment is requested). For example: If you complete this form on April 30, the last day of the month, your disenrollment will be effective the next day, May 1.

I understand unless I enroll in another Medicare Advantage plan, disenrollment from my present Plan reverts my health care coverage to the Original Medicare fee-for-service program.

Retiree Signature* (required if retiree is disenrolling)	Date
Spouse Signature* (required if spouse is disenrolling)	Date
Dependent(s) Signature(s)* (required if dependent(s) are disenrolling)	Date
Dependent(s) Signature(s)* (required if dependent(s) are disenrolling)	Date
Authorized Representative Signature	Date

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 to the Plan or to Medicare upon request.

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

Print Name: ____________________ Signature: ____________________

Address: ____

Telephone Number: (______) _______-__________ Relationship to Member: ________________

Return form to: San Diego Unified School District
4100 Normal Street, Room 1150A
San Diego, CA 92103
FAX: 619.725.8132
employeebenefits@sandi.net