ROCKY MOUNTAIN HEALTH PLANS®

1C

RMHP DualCare Plus (HMO D-SNP) Plan Medicare Disenrollment Form

Please contact RMHP if you need information in another language or format (Braille).

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

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Last Name:	First Name:		Middle Initial:
Address / Apt #:	City:		State:	Zip Code:
Member ID:	Date of Birth:	Sex: ☐ M ☐ F	Home Phone Number:	
Plan Name:	Requested Disenrollment Effective Date:			

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 RMHP 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.

By completing this disenrollment request, I agree to the following:

Rocky Mountain Health Plans (RMHP) will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to get all medical care through RMHP Medicare to get coverage. If I have enrolled in another Medicare health plan I understand that Medicare will cancel my current membership in the Plan on the effective date of that new enrollment. (If I enroll in a Medicare Supplement (Medigap) plan I will not be disenrolled automatically from my current Plan)

I understand there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances.

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 the Plan or Medicare.

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

Name: _____ Address:

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

(Please turn over and complete the other side.)

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I am disenrolling for the following reason (please indicate reason which most closely applies):

- ☐ Moving from plan service area
- ☐ Member Death (please provide copy of death certificate)
- ☐ Premiums too high
- ☐ Moving back to Original Medicare
- ☐ Enrolling with employer group
- ☐ Enrolling in Medicaid
- ☐ Enrolling in VA/TRICARE

Provider Issue

- ☐ PCP does not participate
- ☐ Specialist does not participate
- ☐ Provider location
- ☐ Provider not available for appointment
- ☐ Quality of Service

Unsatisfactory Benefits

- ☐ Services not covered
- ☐ Claims not paid
- ☐ Plan did not cover prescriptions
- ☐ Copays or coinsurance too high
- ☐ Looking for a plan with out-of-network care
- ☐ Plan too confusing
- ☐ Found a better plan

RMHP Customer Service

- ☐ Long telephone wait time
- ☐ Billing Issue
- ☐ Questions not answered
- ☐ Poor overall service

Which type of insurance plan are you changing to?

- ☐ Medicare Advantage, Private Fee For Service (PFFS), Health Maintenance Organization (HMO)
- ☐ Medicare Supplement (Medigap)
- ☐ Part D Only
- ☐ Other _____

Name of plan _____

We appreciate your comments regarding the benefits and services provided by Rocky Mountain Health Plans Medicare Plan.

Were you satisfied with the level of benefits covered by your plan?

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied

Comments: _____

_____

Were you satisfied with the level of service provided by the Plan?

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied

Comments: _____

_____

Would you enroll in another RMHP plan if an opportunity arose? ☐ Yes ☐ No

Send this form to:

Rocky Mountain Health Plans Enrollment

PO Box 10600

Grand Junction, CO 81502-5600

Or fax to RMHP Medicare Enrollment: 970-244-7769

If you have questions please call our Customer Service at 888-282-1420 (TTY dial 711). Hours are 8am - 8pm, 7 days/week, October 1–March 31, and 8am - 8pm, M-F, April1–September 30.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a

Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.