Request for Disenrollment

If you request disenrollment, you must continue to get all medical care from Lasso Healthcare until the effective date of disenrollment. We will notify you of your effective date after we get this form from you.

PLEASE FILL OUT, SIGN, AND RETURN THIS FORM TO:
Lasso Healthcare MSA, 303 W. Madison St, Suite 800 Chicago, IL 60606-3389
or fax this form to 866-365-2776 or 866 ENLASSO
If you have questions while filling out this form, please contact Member Services at 833-925-2766.

Member Name:	
Member ID:	
Requested Disenrollment Date:	

Please choose a qualifying event for disenrollment:

- ❑ It is the Medicare Annual Enrollment Period (AEP). (Annually from October 15 to December 7)
- ❑ I have Medicaid coverage.
- ❑ I have benefits from the Federal Employee Health Benefits Program (FEHBP).
- ❑ I have benefits from the Department of Defense (Tricare) or Veterans Affairs (VA).
- ❑ I have benefits from my employer or union.
- ❑ I have permanently moved outside of the Lasso Healthcare service area.
- ❑ It has been less than one year since I left a Medicare Supplemental plan and this is the first time I’ve been enrolled in a Medicare Advantage plan (Trial Right).
- ❑ I am enrolled in another Medicare Advantage plan (Medicare Supplemental plan does not apply).

Additional Comments:	

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

I acknowledge this request does not guarantee my right to disenroll or guarantee my right to disenroll as of the requested disenrollment date listed above. If I have enrolled in another Medicare Advantage or Medicare Advantage Prescription Drug Plan, I understand Medicare will cancel my current membership in Lasso Healthcare 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.

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 Lasso Healthcare or by Medicare.

Authorized Rep Name:	
Address:	
Phone Number:	
Relationship to Member:	