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 mail this form to:
Lasso Healthcare MSA
P.O. Box 261113
Plano, TX 75026

Member Name:	
Member ID:	
Reason for Disenrollment:	

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. If I have enrolled in another Medicare Advantage or Medicare 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:	

Note to group members: If you are enrolled in Lasso Healthcare Group MSA through an employer, union, or group, please contact your Benefit Administrator to discuss your insurance coverage options prior to submitting this form.