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, P.O. Box 261113 Plano, TX 75026 or fax this form to 800-915-4489

Member Name:	
Member ID:	
Reason for Disenrollment:	
Requested Disenrollment Date:	

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:	