

Special Election Disenrollment Questionnaire

Humana Member ID: _____

Please answer each question “yes” or “no.” Make sure you print your Humana ID number in the space above. Your Humana ID number appears on your Humana ID card.

1. _____ Do you have a low-income subsidy (LIS) or Medicaid?
2. _____ Have you lost your LIS or Medicaid in the past three months?
3. _____ Do you live in a nursing home or other long-term care facility?
4. _____ Do you plan to move into a nursing home or other long-term care facility?
 - If so, when? _____/_____/_____ (MM/DD/YYYY)
5. _____ Have you moved from a nursing home or other long-term care facility in the past three months?
6. _____ Do you have creditable coverage through any of the groups listed below?
“Creditable coverage” means a prescription plan that’s at least as good as Medicare’s basic prescription plan.
 - The Veterans Administration (VA)
 - Tricare
 - Qualified State Pharmaceutical Assistance Program (SPAP) plan
 - Indian or tribal insurance
 - Another carrier
 - Triple S
7. _____ Do you have insurance with:
 - Your employer, retirement plan, union, Consolidated Omnibus Budget Reconciliation Act (COBRA) plan **or**
 - Your spouse’s employer, union, or COBRA?

8. _____ Did you lose insurance with an employer, retirement plan, union, COBRA plan or a spouse's employer, union, or COBRA plan within the past two months?
9. _____ Are you enrolled in – or have you joined – a Program of All-inclusive Care for the Elderly (PACE)?
10. _____ Did you disenroll from a Medicare Supplement or Medigap plan to enroll in your current plan?

Authorization to Complete Disenrollment
Please Print

Member Name (First) (Middle) (Last)

Your Signature* **Date**

Your Phone Number with Area Code

Witness (if required) **Date**

*If the member cannot sign, a person who is authorized to do so under state law in the state where the member lives must sign above. This signature certifies that the person who signs is authorized under state law to complete this disenrollment. It also certifies that written proof of this authority is available if the plan or the Centers for Medicare & Medicaid Services (CMS) request it. CMS is the federal agency that administers Medicare and Medicaid.

If you are the authorized representative, please complete the section below. If we don't have this information, we may not be able to process the disenrollment request.

Name: _____

Relationship to member: _____

Address

Phone Number with Area Code

Please return this signed form and the questionnaire to:

Humana
P.O. Box 14168
Lexington, KY 40512-4168
1-800-457-4708
TTY: 711
6 am to 9 pm

You may also fax us information at 1-800-633-8188.

Thank you.

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in a Humana plan depends on contract renewal.

This information is available for free in other languages. Please call our Customer Care at 1-800-457-4708 (TTY: 711) 6 am to 9 pm.

Esta información está disponible gratis en otros formatos o idiomas. Comuníquese con el Departamento de Servicio al Cliente llamando al 1-800-457-4708 (TTY: 711) 6 am to 9 pm.

本資訊也有其他語言的免費版本可供選擇。請致電 Humana 會員卡背面的電話號碼與客戶服務部聯絡。