

Stanford University Medicare Disenrollment Form

- Complete this form if you are changing from a Medicare Advantage Plan to a Medicare Supplement plan.
- Do not* complete this form if you intend to join another Medicare Advantage plan. You will automatically be disenrolled on the effective date of the new plan.

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Medicare Claim Number

Member Name *(Please Print)*

Street Address

City State Zip

Daytime Phone

Name of Medicare Advantage Plan

(Health Net Seniority Plus, Kaiser Permanente Senior Advantage, PacifiCare SecureHorizons)

Cancel coverage for:

RETIREE SPOUSE

EFFECTIVE DATE

Stanford University Retiree's Name and Social Security number *(If different from individual disenrolling)*

Retiree's Name	Retiree's Social Security Number
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I understand that I must continue to receive medical services from this Plan until the effective date of disenrollment. Disenrollment is effective on the first day of the month following the date this request is received by the Medicare Advantage Plan.

Member's Signature	Date
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Important: Complete a separate Disenrollment Form for each individual disenrolling.

Mail Form To:

Stanford University Benefits Office
655 Serra Street
Stanford, CA 94305-6110

Questions: Call (650) 736-2987 or (877) 905-2987
Press Option 9