



SENIOR ADVANTAGE DISENROLLMENT FORM

This form is to be completed for each member of your family who wishes to discontinue membership in Kaiser Permanente's Senior Advantage Program. If you have any questions please call your local Kaiser Permanente Health Plan Member Services Department. Please return this form to the address below.

NOTE: If you want to join another HMO immediately following termination from Senior Advantage, you do not need to complete this form. Once you enroll in another Medicare contracting HMO, your current membership in Senior Advantage will be terminated automatically.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK			
KAISER MEDICAL RECORD NO.	LAST NAME	FIRST NAME	MI
MEDICARE CLAIM NO.	STREET ADDRESS		
TELEPHONE NUMBER ()	CITY	STATE	ZIP

PLEASE READ AND FILL IN YOUR REQUESTED DATE OF DISENROLLMENT

For Individual Plan members only:

I understand that my disenrollment from Senior Advantage terminates all coverage through Kaiser Permanente effective the date of disenrollment.

For Group members only:

I understand that my disenrollment from Senior Advantage may affect my employer group coverage, and I must contact my Group Benefits Office to complete the termination process.

For all members:

I understand that I must continue to use Kaiser Permanente for all my health care, except for emergencies, out of area urgent care, and authorized referrals, until the effective date of disenrollment.

Disenrollment from Senior Advantage will be effective on the first day of the month after the month Health Plan receives your written disenrollment request (unless you request a later date of disenrollment). For example, if your completed form is received on April 30th, the last day of the month, your disenrollment will be effective the next day, May 1st. If you are requesting a later date of disenrollment please indicate below. The date you request must be for the first day of a month in the future.

MY REQUESTED DATE OF DISENROLLMENT IS _____ / _____ / _____ .

PLEASE SIGN HERE (Your signature, or signature of guardian or conservator*)

Signature: _____ **Date:** _____

* If this is being submitted by a guardian or conservator, please attach legal document establishing guardianship.
Return the white signed form to: Kaiser Permanente, P.O. Box 12685, Oakland, California 94604-2685