# Disenrollment Form

**Each member requesting to be disenrolled must complete their own form.**

If you request disenrollment, you must continue to get all medical care from Health Net Seniority Plus Employer (HMO) until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Health Net Seniority Plus Employer (HMO)'s network. We will notify you of your effective date after we get this form from you.

**If you have any questions, call Health Net Seniority Plus Employer (HMO) at 1-800-275-4737 (TTY: 711). We are available from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.**

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**YOU MAY TYPE TO COMPLETE THIS FORM. YOU MAY ALSO PRINT IT AND FILL IT OUT, IN WHICH CASE PLEASE PRINT YOUR RESPONSES USING BLACK OR BLUE INK. FILL CHECK BOXES IN WITH AN "X".**

Last Name _____ First Name _____ MI__ ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Health Net Seniority Plus Employer (HMO) Subscriber ID Number _____

Medicare Number _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Home Phone Number _____ Mobile Phone Number _____

Permanent Residence Street Address (P.O. Box is not allowed) _____

City _____ State _____ Zip Code _____

Mailing Address if different from permanent residence (P.O. Box is allowed) _____

City _____ State _____ Zip Code _____

Email Address _____

**Please carefully read and complete the following information before signing and dating this disenrollment form:**

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand that Medicare will cancel my current membership with Health Net Seniority Plus Employer (HMO) on the effective date of the new enrollment. I understand that I may 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, due to a late enrollment penalty, for this coverage.

*continued on next page*

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I understand that my signature (or the signature of the person I have authorized to make decisions on my behalf) on this form means I have read and understand the contents of this form. If signed by an authorized representative, this signature certifies that: this person is authorized under State law to complete this disenrollment, and documentation of this authority is available upon request.

Signature*: _____ Today's 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 Health Net Seniority Plus Employer (HMO) or by Medicare.

**If you are the authorized representative, you must sign above and provide the following:**

Name: _____ Phone Number: _____

Address: _____Relationship to the Enrollee: _____

**Typically, you may disenroll from a Medicare Advantage Plan only during the annual enrollment period which takes place from October 15 through December 7 of each year, or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year.**

**There are exceptions which may allow you to disenroll outside of this period. If you have questions about the times you may disenroll, please call Member Services for assistance.**

## ☑ PLEASE SELECT THE DISENROLLMENT REASON THAT APPLIES TO YOU

**Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.**

☐ I recently had a change in my Medicaid (newly qualified for, had a change in level of assistance, or lost eligibility for Medicaid) on _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly qualified for, had a change in level of assistance, or lost eligibility for Extra Help) on _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on _____.

☐ I am joining a PACE program on _____.

☐ I am joining employer group or union coverage on _____. I am requesting a disenrollment date of _____ with the understanding that this is subject to CMS approval.

☐ I was enrolled in a plan by Medicare (or my state) and I want to select a different plan. My enrollment in that plan started or will start on _____.

**If none of these statements applies to you or you're not sure, please contact Health Net Seniority Plus Employer (HMO) at 1-800-275-4737 (TTY: 711), to see if you are eligible to disenroll. We are open from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.**

## ☑ PLEASE SELECT THE REASON WHY YOU ARE LEAVING.

- ☐ PCP not in network
- ☐ Specialist not in network
- ☐ Copays are too high
- ☐ Can't get access to a service
- ☐ Premium is too high
- ☐ Was not aware I was enrolling in this plan

Other _____

**You may return your completed form to:**

Health Net of California
P.O. Box 10420
Van Nuys, CA 91410
Fax: **1-844-222-3180**

## Section 1557 Non-Discrimination Language

## Notice of Non-Discrimination

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Health Net:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services at **1-800-275-4737** (TTY: **711**). From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019** (TDD: **1-800-537-7697**).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

## Sección 1557: Mensaje de No Discriminación

## Notificación de No Discriminación

Health Net cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo.

**Health Net:**

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que puedan comunicarse adecuadamente con nosotros, tales como intérpretes calificados de lengua de señas e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuyo idioma principal no es el inglés, tales como intérpretes calificados e información escrita en otros idiomas.

Si necesita estos servicios, llame a Servicios para Miembros al **1-800-275-4737** (TTY: **711**). Desde el 1 de octubre hasta el 31 de marzo, puede llamarnos los 7 días de la semana, de 8 a.m. a 8 p.m. Desde el 1 de abril hasta el 30 de septiembre, puede llamarnos de lunes a viernes, de 8 a.m. a 8 p.m. Fuera del horario laboral, los fines de semana y los días festivos federales se utiliza un sistema de mensajería.

Si cree que Health Net no le ha brindado estos servicios o que lo(a) ha discriminado de alguna manera por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo, puede presentar una queja formal. Llame al número que aparece más arriba e informe que necesita ayuda para presentar una queja formal. El personal de Servicios para Miembros de Health Net está disponible para ayudarlo(a).

También puede presentar un reclamo sobre derechos civiles ante la Office for Civil Rights del U.S. Department of Health and Human Services, de manera electrónica a través del Portal de Reclamos de la Office for Civil Rights, disponible en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019** (TDD: **1-800-537-7697**).

Los formularios de reclamo están disponibles en **http://www.hhs.gov/ocr/office/file/index.html**.

## 第 1557 條反歧視語言
## 反歧視通知

Health Net 遵循適用的聯邦民權法律，不會根據種族、膚色、國籍、年齡、殘疾或性別歧視他人。

**Health Net：**

- 為殘疾人士提供免費輔助和服務，例如：合格手語翻譯員以及其他格式 (大字版、音訊版、無障礙電子版、其他格式) 的書面資訊，以讓其可以有效地與我們溝通。
- 為非以英語為母語的人士提供免費的語言服務，例如：合格口譯員以及其他語言版本的書面資訊。

如果您需要這些服務，請聯絡會員服務部，電話 **1-800-275-4737** (TTY：**711**)。從 10 月 1 日至 3 月 31 日，您可以致電我們的時間為一週 7 天，上午 8 點至晚上 8 點。從 4 月 1 日至 9 月 30 日，您可以致電我們的時間為週一至週五，上午 8 點至晚上 8 點。非服務時間、週末和聯邦假日會由留言系統接聽。

如果您認為 Health Net 未能提供上述服務或基於種族、膚色、國籍、年齡、殘疾或性別等理由而透過其他方式歧視他人，您可致電上列電話號碼提出申訴，並告知對方您需要協助提出申訴；Health Net 的會員服務部將可為您提供協助。

您也可向美國衛生署和公眾服務部民權辦公室提出民權投訴，您可透過民權辦公室的投訴入口網站 **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** 以電子方式提出投訴，或者透過郵件或電話提出投訴，聯絡資訊如下：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201，**1-800-368-1019** (TDD：**1-800-537-7697**)。

投訴表格可於此網站 **http://www.hhs.gov/ocr/office/file/index.html** 取得。

## Multi-Language Insert
## Multi-language Interpreter Services

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**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-275-4737** (TTY: **711**). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Contamos con los servicios gratuitos de un intérprete para responder las preguntas que tenga sobre nuestro plan de salud o de medicamentos. Para obtener un intérprete, llámenos al **1-800-275-4737** (TTY: **711**). Alguien que habla español puede ayudarle. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的口译服务，可解答您对我们的健康或药物计划的有关疑问。如需译员，请拨打 **1-800-275-4737**（TTY：**711**）。您将获得讲汉语普通话的译员的帮助。这是一项免费服务。

**Chinese Cantonese:** 我們提供免費的口譯服務，可解答您對我們的健康或藥物計劃可能有的任何疑問。如需口譯員服務，請致電 **1-800-275-4737** (TTY：**711**)。會說廣東話的人員可以幫助您。此為免費服務。

**Tagalog:** May mga libre kaming serbisyo ng interpreter para sagutin ang anumang posible ninyong tanong tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang kami sa **1-800-275-4737** (TTY: **711**). May makakatulong sa inyo na nagsasalita ng Tagalog. Isa itong libreng serbisyo.

**French:** Nous proposons des services d'interprètes gratuits pour répondre à toutes vos questions sur notre régime de santé ou de médicaments. Pour obtenir les services d'un interprète, appelez-nous au **1-800-275-4737** (TTY: **711**). Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào về chương trình sức khỏe hoặc chương trình thuốc của chúng tôi. Để nhận thông dịch viên, chỉ cần gọi chúng tôi theo số điện thoại **1-800-275-4737** (TTY: **711**). Một nhân viên nói tiếng Việt có thể giúp quý vị. Dịch vụ này được miễn phí.

**German:** Wir bieten Ihnen einen kostenlosen Dolmetschservice, wenn Sie Fragen zu unseren Gesundheits- oder Medikamentenplänen haben. Wenn Sie einen Dolmetscher brauchen, rufen Sie uns unter folgender Telefonnummer an: **1-800-275-4737** (TTY: **711**). Ein deutschsprachiger Mitarbeiter wird Ihnen behilflich sein. Dieser Service ist kostenlos.

**Korean:** 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우, **1-800-275-4737**(TTY: **711**)번으로 당사에 연락해 주십시오. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

**Russian:** Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, вам доступны бесплатные услуги переводчика. Если вам нужен переводчик, просто позвоните нам по номеру **1-800-275-4737** (TTY: **711**). Вам окажет помощь сотрудник, говорящий на русском языке. Данная услуга бесплатна.

**Arabic:** نوفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-800-275-4737** (TTY: **711**). يمكن أن يساعدك شخص يتحدث العربية. وتتوفر هذه الخدمة بشكل مجاني.

**Hindi:** हमारे स्वास्थ्य या ड्रग प्लान के बारे में आपके किसी भी सवाल का जवाब देने के लिए, हम मुफ़्त में दुभाषिया सेवाएं देते हैं। दुभाषिया सेवा पाने के लिए, बस हमें **1-800-275-4737** (TTY: **711**) पर कॉल करें। हिन्दी में बात करने वाला सहायक आपकी मदद करेगा। यह एक निःशुल्क सेवा है।

**Italian:** Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il numero **1-800-275-4737** (TTY: **711**). Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

**Portuguese:** Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número **1-800-275-4737** (TTY: **711**). Um falante de português poderá ajudá-lo. Este serviço é gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-275-4737** (TTY: **711**). Yon moun ki pale Kreyòl Ayisyen ka ede w. Se yon sèvis gratis.

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**Polish:** Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer **1-800-275-4737** (TTY: **711**). Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

**Japanese:** 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、**1-800-275-4737**（TTY：**711**）にお電話ください。日本語の通訳担当者が対応します。これは無料のサービスです。