Health Net®
LIFE INSURANCE COMPANY

CALIFORNIA FARM BUREAU FEDERATION

HEALTH NET LIFE MEDICARE SUPPLEMENT DISENROLLMENT FORM

With your requested disenrollment, you must continue to receive all medical care from the Health Net Life Medicare Supplement Program until the effective date of disenrollment. Health Net Life Insurance Company (Health Net Life) will notify you of your disenrollment effective date when your form has been received and processed. Please fax your form to Health Net Life Medicare Supplement Enrollment Services at 1-866-214-1992 or mail to Attn: Health Net Life Medicare Supplement Enrollment Services, PO Box 10420, Van Nuys, CA 91410.

Last name:	First name:	Middle initial:
Medicare # (SSN or Health Net ID #):		
Date of Birth: __ __/__ __/__ __ __ __ MM/DD/YYYY	Gender: ☐ Male ☐ Female	Home telephone: ( ) -

Request for disenrollment from the following Health Net Life Medicare Supplement Plan:
Individual Plans: ☐ A ☐ C ☐ E ☐ F ☐ F+ (High Ded.) ☐ G ☐ H ☐ I
Farm Bureau Plans: ☐ A ☐ BB ☐ C ☐ F ☐ F+ (High Ded.) ☐ G ☐ J

Reason(s) for disenrollment: check all that apply
☐ Premium ☐ Claims ☐ Billing ☐ Customer service ☐ Out of service area
☐ Elected another Insurance carrier Name of Insurance carrier _____
What type of plan did you elect? ☐ Medicare Supplement Plan ☐ Medicare Advantage Plan
☐ Other reason: _____
_____

Are you transitioning from a Health Net Life Medicare Supplement Plan to a Health Net Medicare Advantage Plan?
☐ YES ☐ NO If yes, what Health Net Medicare Advantage Plan did you elect?
_____

Please allow 7–10 business days for processing. To check the status of your disenrollment, please call Member Services at 1-800-926-4178, Monday through Friday, 8:00 a.m. to 6:00 p.m., except holidays.

By signing this disenrollment request, I understand any premium payments received in advance of or after the above requested disenrollment effective date are subject to refund. If I am on the Automatic Bank Draft (ABD) program, I may be drafted after my disenrollment date. I understand that all refunds are in the form of a live check.

Your signature[1]**:** _____ **Date:** __ __/__ __/__ __ __ __
MM/DD/YYYY

[1]Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 Life Insurance Company or by Medicare.

If you are the authorized representative, you must provide the following information:

Name:_____

Address:_____

Phone number: (____) _____ - _____

Relationship to enrollee: _____

White Copy – Health Net Yellow Copy – Medicare Programs Pink Copy – Member