UnitedHealthcare Medicare Advantage Opt-Out Form

Welcome to the UnitedHealthcare Group Medicare Advantage plan (UHC Medicare Advantage) provided by the Local Government Health Insurance Board (LGHIB). You will be automatically enrolled in this plan unless you complete this form and return it to the LGHIB at the address shown below.

If you have a Medicare Advantage or Medicare Part D prescription drug plan and want to disenroll from the Local Government Health Insurance Program's (LGHIP) UHC Medicare Advantage Plan, please complete this form and return it to the LGHIB prior to the date you want to disenroll from the UHC Medicare Advantage Plan. If you are enrolled in any other Medicare Advantage plan or Medicare Part D prescription drug plan and you want to stay on that plan, you must complete and return this UHC Medicare Advantage Opt-Out form.

If you do not want to be enrolled in this plan provided by the LGHIP, please complete and return this form.

I am a (please check one of the following): _____Medicare retiree _____Medicare dependent of retiree

Subscriber's Name:		
Subscriber's Contract Number:	Subscriber's Social Security Number:	Subscriber's Telephone Number:

I understand that the coverage available to Medicare retirees is the UHC Medicare Advantage Plan provided by the LGHIB. If I choose to disenroll from the UHC Medicare Advantage Plan, I will not have any health insurance coverage with the LGHIB and will not be allowed to re-enroll into the UHC Medicare Advantage Plan provided by the LGHIB. I further understand that if I chose to disenroll from the UHC Medicare Advantage Plan, I may be subject to a Late Enrollment Penalty if I later chose to enroll in another Medicare Part D prescription drug plan depending on how long there is a gap in my prescription drug coverage.

I understand that I can only be enrolled in one Medicare Advantage plan or Medicare Part D prescription drug plan at a time.

I certify that I have completely read and fully understand the terms and conditions of submitting this form. I also attest that all representations made by me on this form are true and correct.

_____ _____

Member's signature Date

Remember: Each member with Medicare who wishes to disenroll must submit a separate form.

If signed as a Personal Representative, you must provide documentation of your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (e.g., Parent, Power of Attorney, Guardianship, or Conservatorship).

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