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2021 **PEBB Medicare Advantage Plan Disenrollment Form**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

This is a request to terminate enrollment in a PEBB Medicare Advantage plan.
Type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example: J O H N
Inaccurate, incomplete, or illegible information may delay coverage. The information written on this form replaces all enrollment forms previously submitted.

Subscriber last name

Medicare number

1 **I wish to terminate enrollment in** (check one)**:**

Kaiser Foundation Health Plan of the Northwest

☐ Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington

☐ Kaiser Permanente WA Medicare Advantage

UnitedHealthcare

☐ UnitedHealthcare PEBB Balance

☐ UnitedHealthcare PEBB Complete

Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

Effective date of termination

2021 PEBB medical contractors

Do not send forms to the addresses below. This information is for reference only.

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
1-877-221-8221 (TTY: 711)

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100
Seattle, WA 98101
1-866-648-1928 or TTY: 1-800-833-6388

UnitedHealthcare
Customer Service Department
PO Box 30770
Salt Lake City, UT 84130-0770
1-855-873-3268 (TRS: 711)

2 Signatures

The Health Care Authority (HCA) must process this form. To disenroll from a Medicare Advantage plan or Medicare Advantage Prescription Drug plan, the change in enrollment must be allowed under federal regulations. **Your enrollment in a Medicare Advantage plan will terminate on the last day of the month in which HCA receives this form and any other required forms**.

If you are a retiree receiving benefits through the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS.

Only the members requesting termination should sign the form.

Subscriber

Last name

First name

Medicare number

Signature

Date

Spouse or state-registered domestic partner

Last name

First name

Medicare number

Signature

Date

Please sign, date, and keep a copy for your records. Submit form and documentation using one of the methods below:

Mail to:

Washington State Health
Care Authority
PO Box 42684
Olympia, WA 98504-2684

Fax to:

360-725-0771

Electronically submit:

Send a secure online message to PEBB Customer Service by registering for an account on HCA's website at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

HCA is committed to providing equal access to our services. If you need accommodation, please call us at 1-800-200-1004 (TRS: 711).

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, go to the HCA website at **hca.wa.gov/erb**.