

2022 PEBB Medicare Advantage Plan Disenrollment Form

This is a request to terminate enrollment in a PEBB Medicare Advantage plan. If you request disenrollment, you must continue to get all medical care from your current PEBB plan until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of the network. We will notify you of your effective date after we get this form from you.

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

Effective date of termination

! 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.

2022 PEBB Program 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 (TRS: 711)

Kaiser Foundation Health Plan of Washington

1300 SW 27th Street
Renton, WA 98057
1-866-648-1928
TTY: 1-800-833-6388

UnitedHealthcare

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



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. Please sign, date, and keep a copy for your records.

Subscriber

Last name

First name

Medicare number

Signature

Date

Spouse or state-registered domestic partner

Last name

First name

Medicare number

Signature

Date

Form return

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:

1-360-725-0771

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.

Note: This is separate from PEBB My Account.

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/pebb-retirees.