Please print your name clearly here

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DISENROLLMENT CHECKLIST

Typically, you may disenroll from a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to disenroll from a Medicare prescription drug plan outside of this period.

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.

If none of these statements applies to you or you're not sure, please contact ***BlueRx (PDP)*** at **1-800-327-3998 (AL) /1-888-311-7508 (TN)** (**TTY** users should call **711**) to see if you are eligible to disenroll. **We are open Monday – Friday, 8 a.m. – 8 p.m. CST. From October 1 to March 31, the hours of operation are Monday – Sunday, 8 a.m. – 8 p.m. CST.** You may be required to leave a message for calls made after hours, weekends and holidays. Calls will be returned the next business day.

BlueRx is a PDP with a Medicare contract. Enrollment in **BlueRx (PDP)** depends on contract renewal.

BlueRx (PDP) is provided by Blue Cross and Blue Shield of Alabama and UTIC Insurance Company, independent licensees of the Blue Cross and Blue Shield Association.

PLEASE CHECK ALL ITEMS THAT APPLY.

- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ______________________.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ______________________.
- ☐ 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 or long-term care facility). I moved/will move into/out of the facility on (insert date) ______________________.
- ☐ I am joining a PACE program on (insert date)______________________.
- ☐ I am joining employer or union coverage on (insert date)______________________.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)______________________.