BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Advantage®

DISENROLLMENT FORM

If you have already joined or intend to join a new Medicare managed care plan or other Medicare Advantage Plan (like a PPO, Private Fee-for-Service Plan, etc.), you do not have to complete this form.

Date:__________________

Member's Name:	First	Middle	Last

Address:	City	State	Zip	County

Telephone:		☐ Male ☐ Female	Date Of Birth

Medicare Number	Contract Number

Please carefully read and complete the following information before signing and dating this disenrollment form:

On the effective date of enrollment in another Medicare managed care or other Medicare Advantage Plan, Medicare will automatically cancel your current membership in Blue Advantage.

If you request disenrollment, you must continue to receive all medical care from ***Blue Advantage*** until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Blue Advantage's network. We will notify you of your effective date after we have received this form from you.

Requested Disenrollment Date ____

Beneficiary Signature ____ Date: __________________

OR

Beneficiary Guardian Signature ____ Date: __________________