



DIENROLLMENT REQUEST – SISC GROUP PLAN

Use to disenroll from the following plans:

- BLUE SHIELD 65+ HMO/ Medicare Advantage Plan
- COMPANIONCARE / Medicare Supplement Plan or
- KAISER SENIOR ADVANTAGE / Medicare Advantage Plan

Member Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone: () _____ - _____ Date of Birth: ____/____/____ SS#: _____

Please read carefully and initial next to your request before signing and dating the form.

DIENROLLMENT FROM COMPANIONCARE:

When the medical portion of this plan is terminated then the Medicare Part D prescription drug plan is also terminated automatically with the same termination date.

_____ I wish to disenroll from CompanionCare/Medicare Supplement (Leave SISC Coverage)

Initial

_____ I wish to disenroll from CompanionCare and enroll in a SISC Medicare Advantage Plan
(must be offered by district)

Initial

DIENROLLMENT FROM MEDICARE ADVANTAGE PLAN:

Blue Shield Medicare Advantage or Kaiser Senior Advantage

Members who have requested to disenroll must continue to receive all medical care from their HMO plan until the effective date of the disenrollment except for emergencies, out of area urgent care or authorized referrals.

_____ I wish to disenroll from SISC coverage (Returns member to Medicare coverage)

Initial

_____ I wish to disenroll from Kaiser Senior Advantage & enroll with Kaiser direct (Leave SISC Coverage)

Initial

_____ I wish to disenroll from my Medicare Advantage Plan & enroll in CompanionCare
(must be offered by district)

Initial

REQUESTED DIENROLLMENT DATE: _____

Medicare benefits may only be restored on the first of a month. Disenrollment request requires a 45 calendar day advance notice. NO Exceptions

I understand that by leaving SISC coverage I may not re-enroll at a later date.

Member Signature: _____ Date: _____

Return to SISC via Secure File Transfer.

*Drop-Off to SISHealthActivity@kern.org using <https://filetransfer.kern.org>

<http://sisc.kern.org/hw>

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