Devoted
HEALTH PLANS

Leaving your Devoted Health plan (Disenrollment)

Fill out this form to switch to Original Medicare **without** a Medicare prescription drug plan.

If you join another Medicare Advantage plan or a Medicare prescription drug plan, you don't need this form. Your Devoted Health plan will end automatically when your new plan starts.

1. Check that you can leave your plan right now

You can leave a Medicare Advantage plan:

- **October 15 to December 7** (Medicare Annual Enrollment Period)
- **January 1 to March 31** (Medicare Advantage Open Enrollment Period)
- During a **Special Enrollment Period**

Do I qualify for a Special Enrollment Period?
Check any boxes that are true for you. By checking a box, you're saying that to the best of your knowledge, you qualify for a Special Enrollment Period.

❏ I have Medicare and Medicaid, or my state helps pay my Medicare monthly payments.

❏ I get Extra Help paying for Medicare prescription drugs.

❏ I live in a long-term care facility, like a nursing home.

❏ I just lost Medicaid on ___/___/_____ (month/day/year).

❏ I just lost my Extra Help paying for Medicare prescription drugs on ___/___/_____.

❏ I'm moving (or recently moved) to or from a long-term care facility on ___/___/_____.

❏ I'm joining a PACE program on ___/___/_____.

❏ I'm joining employer or union health insurance on ___/___/_____.

❏ Medicare (or my state) signed me up for this plan, but I want to choose a different plan. My plan started on ___/___/_____.

Not sure if you qualify? Call us at 1-800-338-6833 (TTY 711).
We'll help you find out if you can leave your plan right now. We're here 8am to 8pm, Monday to Friday. From October 1 to March 31, we're here 8am to 8pm, 7 days a week.

2. Add your information

First name:	**Middle initial:**
Last name:	
Birth date: _____ /_____ /_____ (month/day/year)	
Medicare number: __ __ __ __ - __ __ __ - __ __ __ __	
Phone number: (__ __ __) __ __ __ - __ __ __ __	

3. Sign the form

By signing below, I understand that:

- I might not be able to join another plan at this time
- If I leave my Medicare prescription drug coverage now — and then sign up for Medicare prescription drug coverage in the future — I may have to pay more for it each month

Signature: (yours or your legal representative's)	**Date:**
I'm signing this form for: ___ Myself ___ Someone else	

If you're signing for someone else:

Your name:	**Your relationship to them:**
Your address:	
Your phone number: (__ __ __) __ __ __ - __ __ __ __	
By signing this form on behalf of someone else, I agree that: • I am legally allowed to act on their behalf in the state where they live • If Devoted Health or Medicare asks, I or they will provide paperwork to prove this	

4. Mail or fax your completed form to us

FLORIDA:

Mail:
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

Fax: 1-833-434-0535

ALL OTHER STATES:

Mail:
Devoted Health – Enrollment
PO Box 211127
Eagan, MN 55121

Fax: 1-877-264-3859

When will my Devoted Health plan end?
After we process your form and check that you're allowed to change plans right now, we'll send a letter that says what day your plan will end.

Until then, make sure to only see providers in our network. To avoid any surprise costs, call us at 1-800-338-6833 (TTY 711) to check that your plan has ended before you see any out-of-network providers.

Devoted Health is an HMO and PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Y0142_22M255_C