Medicare Supplement Disenrollment Form

BlueCross BlueShield Minnesota

(Please print in ink.)

A Personal information

Member's name Last First MI

Gender ☐ Male ☐ Female

Permanent residence street address Street City State ZIP

Phone _____

County _____

Birthdate _____

Member identification number _____

B Authorization and acknowledgments

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

Disenrollment from the Medicare Supplement plan will be effective on the first day of the month after the month Blue Cross Blue Shield of MN receives the written request (unless you request a later date of disenrollment). For example, if Blue Cross Blue Shield of Minnesota receives this completed form on April 30, the last day of the month, your disenrollment will be effective the next day, May 1.

Requested disenrollment date: _____

Your Signature:* _____ **Date:**_____

*Or the signature of the person authorized to act on your behalf under the laws of the state where you live.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this disenrollment form means that I have read and understand the content of this disenrollment form. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under state law to complete this disenrollment and 2) documentation of this authority is available upon request by Blue Cross and Blue Shield of Minnesota or Medicare.

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____-_____

Relationship to Enrollee: _____

Please return the completed form to:

Blue Cross and Blue Shield of Minnesota
PO Box 982801
El Paso, TX 79998-2801
Fax: (651) 662-6315

X22356R01 (01/23)