MyTruAdvantage | P.O. Box 428 Columbus, IN 47202-0428 | 844.425.4280 | www.MyTruAdvantage.com

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

Last Name:	First Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Member/Medicare Number:			
Birth Date:	Sex: ☐ M ☐ F		Home Phone Number: ( )

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

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in MyTruAdvantage on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescrption drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

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

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. 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 MyTruAdvantage or by Medicare.

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

Name: _____

Address: _____

Phone Number: ( ) _____-_____

Relationship to Enrollee: _____