Trinity Health Plan
Of New England

3100 Easton Square Place
Suite 300
Columbus OH 43219
Phone: 800-240-3851
Fax: 833-256-2871

Disenrollment Form

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Health Plan Of New England 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 prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Submit completed form via fax to 1-833-256-2871.

Membership Information

First Name	Last Name	Middle Initial
Member ID	**Date of Birth**	**Phone Number**
Medicare Number	**Sex** ☐ **Male** ☐ **Female**	

Please carefully read and complete the following information before signing and dating this disenrollment form:
I understand that I am ending my optional supplemental dental benefits from Health Plan Of New England. Disenrollment will be effective the 1st of the month following the receipt of this written notification. I am responsible for the dental premium until I receive confirmation of disenrollment from dental from Health Plan Of New England. No monthly pro-ration of premiums will be considered.

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 Health Plan Of New England or by Medicare.

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

First Name	Last Name	Middle Initial
Street Address	**City**	**State**
Zip	**Phone Number**	**Relationship to Enrollee**

If none of these statements apply to you or you're not sure, please call Health Plan Of New England at 1-800-240-3851 (TTY users should call 711) to see if you are eligible to disenroll.
We are open 8 a.m. – 8 p.m., 7 days a week.

Turn page – More Information on Back

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an election period.

- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost my Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I am joining a PACE program on (insert date) _____.
- ☐ I am joining employer or union coverage on (insert date) _____.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment started on (insert date) _____.

If none of these statements apply to you or you're not sure, please call Health Plan Of New England at 1-800-240-3851 (TTY users should call 711) to see if you are eligible to disenroll.
We are open 8 a.m. – 8 p.m., 7 days a week.