Blue Cross MedicareRx
Drug Plan Disenrollment Form

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of the effective date of your disenrollment after we process this form.

Employer, Union or Group Sponsor Name **LAPRA – MedicareRx**	Group #	Requested Disenrollment Date: (_ _/_ _/ _ _ _ _) MM/DD/YYYY	
Last Name	First Name	MI	☐Mr. ☐Mrs. ☐Ms.
Permanent Residence Street Address	City	State	ZIP Code

Member Identification Number	Date of Birth (_ _/_ _/ _ _ _ _) MM/DD/YYYY	☐Male ☐Female	Phone Number (____) -____ - _______

By completing this disenrollment request, I agree to the following:

<Plan Name> will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at <Plan Name> network pharmacies in order to receive the highest level of my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare Prescription Drug Plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not enroll in another Medicare Prescription Drug Plan at this time, or within 63 days of my date of termination, I may have to pay a penalty for this coverage in the future.

Signature:	Today's Date:

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

Name____

Address____

City____State________ZIP Code___________

Phone Number (___) - ___ - ________ Relationship to Enrollee ______________________________

Please return this disenrollment form to:

Los Angeles Police Relief Association, Inc.
600 N. Grand Avenue
Los Angeles, CA 90012.

Anthem Blue Cross Life and Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal. Anthem Blue Cross Life and

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