58861

NDPERS PRESCRIPTION DRUG PLAN (PDP) DISENROLLMENT FORM

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58861 (Rev. 10-2021)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

Disenrollment Instructions

Before you make your decision, please examine all your options to be sure you understand the plan coverages, eligibility and enrollment opportunities for other coverage. By cancelling your prescription drug plan coverage, you will no longer be able to participate in the NDPERS Dakota Retiree Plan medical coverage.

If you wish to disenroll from the NDPERS Prescription Drug Plan (PDP) provided through Humana Group Medicare, please carefully read and complete all sections on this form and submit to NDPERS along with a Request to Cancel Retiree Health Insurance Coverage SFN 58269 by the end of the month **prior to** the disenrollment effective date. I understand that the form must be signed in the month prior to the requested disenrollment date.

PART A MEMBER INFORMATION

Name of Individual Requesting the PDP Disenrollment (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Medicare Claim Number	
Member's Name (Last, First, Middle)	NDPERS Member ID

PART B MEDICARE PDP DISENROLLMENT AGREEMENT & AUTHORIZATION

By completing this Medicare PDP disenrollment request, I agree to the following

I understand that until my disenrollment is effective, I must continue to fill my prescriptions through Humana Group Medicare network pharmacies in order to receive 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 special circumstances.

I understand that I am disenrolling from my NDPERS Prescription Drug Plan (PDP) and, if I do not enroll in another Medicare Prescription Drug Plan or a Medicare Advantage with a Prescription Drug Plan at this time, or have other coverage as good as Medicare, I may have to pay a penalty for this coverage in the future.

I understand that by disenrolling from the NDPERS Prescription Drug Plan (PDP), I will no longer be able to participate in the NDPERS Dakota Retiree Plan for medical coverage.

Please √ mark the box next to the reason(s) that applies to why you are disenrolling from the NDPERS Prescription Drug Plan (PDP) Coverage

☐	Due to loss of Medicare
☐	I no longer live within the service area
☐	Enrolled in another Medicare Prescription Drug Plan. Enrollment Date _____/____/___
☐	I have other coverage equal to the Medicare Prescription Drug Coverage. Enrollment Date ____/____/____
☐	Other (Please Specify)

Requested Disenrollment Date

Signature of Individual Requesting Disenrollment from NDPERS PDP (Electronic signatures will not be accepted)	Date