

County of Santa Barbara Medicare Part D

Disenrollment Request

Please complete the Disenrollment Request below.

1. I understand that by signing this Disenrollment Request, I elect to disenroll from the County of Santa Barbara PDP Plan. I further understand that I will no longer be eligible (as of the effective date described below) to participate in the County Retirement Medical Plan.
2. I understand that the effective date of disenrollment generally will be the first day of the month following the date Aetna receives the Disenrollment Request. Aetna will then send me a confirmation letter of disenrollment upon notification from the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare.

Member Information *(please print clearly in ink)*

Name (exactly as it appears on Aetna ID card)		
Member Identification Number ME _____	Telephone Number (____) ____ - ____	
Address (Number and Street, Apartment Number)		
City	State	Zip
Reason for Disenrolling (optional)		
Member Signature	Date	

This request must be signed by the member unless there is an appointed Durable Power of Attorney, a copy of which must be attached. Please fax the completed form to the following number:

**Debbi Cooper
Fax: (860)975-9630**

**And Kim Shapiro
Fax: (860) 975-9076**