Clover
Disenrollment Form

Typically, you may only disenroll from a Medicare Advantage plan during the Annual Enrollment Period (**October 15** through **December 7** of each year) or during the Medicare Advantage Disenrollment Period (**January 1** through **February 14** of each year). There are circumstances that may allow you to disenroll from a Medicare Advantage plan outside those periods.

By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for a Special Election Period. If none of these statements applies to you or if you're not sure, call us at (888) 657-1207 (TTY 711). We'll help determine if you're eligible to disenroll.

We're open 8:00 am–8:00 pm, local time, 7 days a week. From February 15th through September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Return to Clover Health
Mail:

PO BOX 471
Jersey City, NJ 07303-9919

Fax: 1 (866) 508-0865

Read the following statements carefully and check the box if the statement applies to you.

- ☐ I am requesting an end-of-year disenrollment during the Annual Enrollment Period (AEP) from October 15 through December 7.
- ☐ I am requesting disenrollment during Medicare Advantage Disenrollment Period from January 1 through February 14.
- ☐ This was my first year with a Clover plan, and I dropped a Medigap plan I had prior to this plan.
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ I get Extra Help (LIS) paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for a state Medicaid program or Extra Help (PAAD) that helps pay for my Medicare prescription drugs. I stopped receiving assistance on (insert date) _____.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (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 have or will be enrolling in a prescription drug plan (like TRICARE or VA coverage) that provides coverage that's as good as Medicare prescription drug coverage.

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

Please provide the following information:				
LAST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.	Sex: ☐ M ☐ F	Birth Date: ____/____/_____ (MM / DD / YYYY)
FIRST Name:				
Medicare #: __ __ __ - __ __ - __ __ __ __ - __	Home Phone: (__ __ __) __ __ __ - __ __ __ __			

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

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Clover Health 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. 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 Clover Health or by Medicare.

YOUR SIGNATURE:	**DATE:**

If you are the authorized representative, you must sign above and provide the following information:
Name:
Street Address:
Phone Number:
Relationship to the Enrollee: