BlueCross BlueShield Minnesota

Medicare Supplement Disenrollment Form

(Please print in ink)

A Personal information

Member's name *Last* *First* *MI*

Gender ☐ Male ☐ Female

Permanent Residence Street Address *Street* *City* *State* *Zip*

Phone ( ) __ __ __ - __ __ __ __

County

Birthdate __ __ / __ __ / __ __ __ __

Member identification number _____

B Authorization and acknowledgements

Requested disenrollment date: __ __ / __ __ / __ __ __ __

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 disenrollment form means that I have read and understand the contents of this disenrollment form. If signed by an authorized representative (as described above), this signature certifies that: 1) this person is authorized under state law to complete this disenrollment form; and 2) documentation of this authority is available upon request by Blue Cross and Blue Shield of MN or Medicare.

Your signature _____ Date _____

Authorized representative signature _____ Date _____

Please return the completed form to:

Blue Cross and Blue Shield of Minnesota
PO Box 982801
El Paso, TX 79998-2801
Fax: (651) 662-6315