MEDICARE ADVANTAGE PLAN DISENROLLMENT FORM

Commonwealth of Massachusetts
Group Insurance Commission

CHANGING GIC MEDICARE PLAN

I am disenrolling from the following Medicare Advantage plan and enrolling in another GIC Medicare Plan.

____ Tufts Medicare Preferred

Insured must complete this section:

Please disenroll me from my health plan.

Name: _____ GIC ID No. _____
(Please print)

_____ _____
Signature of Insured Date

Spouse, if applicable, must complete this section:

I am the spouse of GIC Insured, _____, and wish to disenroll from my health plan.
(Please print)

Name: _____ GIC ID No. _____
(Please print)

_____ _____
Signature of Spouse Date

Medicare Dependent, if applicable, must complete this section:

I am the dependent of GIC Insured, _____, and wish to disenroll from my health plan.
(Please print)

Name: _____ GIC ID No. _____
(Please print)

_____ _____
Signature of Dependent Date