



PEBB Medicare Advantage Plan Disenrollment Form

This is a request to disenroll from a PEBB Medicare Advantage plan.
(Please print in black ink.)

I wish to disenroll from:	
Medical plan (Check one.) <input type="checkbox"/> Group Health Cooperative <input type="checkbox"/> Group Health Medicare Advantage Classic <input type="checkbox"/> Group Health Medicare Advantage Value <input type="checkbox"/> Kaiser Foundation Health Plan of the Northwest <input type="checkbox"/> Kaiser Permanente Classic <input type="checkbox"/> Kaiser Permanente Value <input type="checkbox"/> PacifiCare of Washington, Inc. <input type="checkbox"/> Secure Horizons Classic <input type="checkbox"/> Secure Horizons Value	Effective date of change
Subscriber's name	Date
Subscriber's signature	
Medicare number	
<p>We understand the Health Care Authority must process this form and that our enrollment in a Medicare Advantage plan will end on the last day of the month after our health plan receives this completed form.</p> <p>HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to www.hca.wa.gov.</p>	
Spouse or qualified domestic partner's name	Date
Spouse or qualified domestic partner's signature	
Medicare number	

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<p>2008 PEBB MEDICAL CONTRACTORS</p> <p>Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233 Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099 PacifiCare of Washington, Inc., 7525 SE 24th Street, Suite 200, P.O. Box 9005, Mercer Island, WA 98040-9005</p>
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Please return this form to:
 Washington State Health Care Authority
 P.O. Box 42684
 Olympia, WA 98504-2684