



Disenrollment Form

Please fill out and carefully read all information before signing and dating the disenrollment form. You must complete one form for each eligible family member who wishes to disenroll.

Please fax or mail this form to the Plan for processing. Our fax number is 571-599-7475. Our mailing address is:

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

Last Name	First Name	Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
NALC Member ID		Medicare ID	
Birth Date		Home/Cell Phone Number ()	
Physical Address		Mailing Address (if different)	

By completing this disenrollment request, I agree to the following:

SilverScript will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions using the SilverScript ID card.

Signature:* _____ Date: _____

- * Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 Medicare.

<p>If you are the authorized representative, you must provide the following information:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: (____) ____ - _____ Relationship to Enrollee: _____</p>
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