SilverScript®

PSHB

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	□ Mr. □ Mrs. □ Miss □ 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:
I understand that by opting out of or disenrolling from SilverScript PDP, I will lose all prescription drug coverage under the NALC Health Benefit Plan. 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.

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____ - _____ **Relationship to Enrollee:** _____