Excellus
A nonprofit independent licensee of the Blue Cross Blue Shield Association
PO Box 211316
Eagan, MN 55121

If you request disenrollment, you must continue to get all dental care from your Medicare Optional Supplemental Dental plan until the effective date of disenrollment. Contact us to verify your disenrollment before you seek dental services outside of Medicare Optional Supplemental Dental coverage's network. We will notify you of your effective date after we get this form from you.

Last name:	First Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Medicare #			
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )	

Please carefully read and complete the following information before signing and dating this disenrollment form:

I understand that if I am disenrolling from my Medicare Optional Supplemental Dental coverage and want Medicare dental coverage in the future, I may have a gap in that dental coverage.

Your Signature*: ______________________________ **Date:** _________________

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. 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 Excellus BlueCross BlueShield or by Medicare.

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

Name :__________________________________
Address: ____
Phone Number: (___) _____-_____
Relationship to Enrollee _______________________________