Blue Cross® Medicare Supplement & Legacy℠ Medigap Dental Vision Hearing Package Disenrollment Form

Blue Cross Blue Shield Blue Care Network of Michigan

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Medicare number		Blue Cross Enrollee ID	
Birth date	Sex ☐ M ☐ F	Home phone number ( )	

Please check the box below:

☐ I want to be disenrolled from my Dental Vision Hearing Package benefit.

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

If I voluntarily disenroll from the Dental Vision Hearing Package, I understand I will not be able to re-enroll in the package until February 1 through April 30 of the following year. Disenrollment from the Medicare Supplement Dental Vision Hearing Package will be effective the first of the month following the date Blue Cross Blue Shield of Michigan receives my request.

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 Blue Cross or by Medicare.*

If you are the authorized representative, you must provide the following information (please print)

Name	
Relationship to enrollee	Phone number ( )

Please fax completed form to: 1-866-392-7528

Or mail to: Blue Cross Blue Shield of Michigan
MC 610B
P.O.Box 44407
Detroit, MI 48244-0407

You can also call Customer Service at: 1-888-216-4858