UnitedHealthcare® Medicare Advantage Opt-out Form

Welcome to the UnitedHealthcare® Group Medicare Advantage Plan (UHC Medicare Advantage Plan) provided by the State Employees' Insurance Board (SEIB). You will be automatically enrolled in this plan unless you complete this form and return it to the SEIB at the address shown below. **If you want to remain in this plan, no action is required and you may discard this form.**

If you have a Medicare, Medicare Advantage and/or Medicare Part D prescription drug plan through an entity other than the SEIB and want to disenroll from the UHC Medicare Advantage Plan provided by the SEIB, please complete this form and return it to the SEIB prior to the date you want to disenroll from the UHC Medicare Advantage Plan.

Each Medicare member (subscriber and dependent) enrolled through the SEIB who wishes to opt-out of the UHC Medicare Advantage Plan must complete and return this form.

I am a (please check one of the following):

Medicare retiree	Medicare dependent of retiree
Medicare surviving spouse	Medicare dependent of surviving spouse

Subscriber Information

Subscriber's Name (First, Middle Initial, Last):			Subscriber's Date of Birth:	
Subscriber's Contract Number:	Subscriber's Medicare Number:	Subscriber's Part A Date:	Subscriber's Part B Date:	
Street Address:		City:	State:	ZIP Code:
Mailing Address (If different from Street Address):		City:	State:	ZIP Code:
Home Phone Number:	Cell Phone Number:	E-Mail Address:		

Dependent Information

Medicare Dependent's Name (First, Middle Initial, Last):		Dependent's Date of Birth:
Dependent's Medicare Number:	Dependent's Part A Date:	Dependent's Part B Date:

I understand the coverage available to Medicare retirees is the UHC Medicare Advantage Plan provided by the SEIB. If I choose to disenroll from the UHC Medicare Advantage Plan, I will not have health or drug coverage through the SEIB. I further understand that if I choose to disenroll from the UHC Medicare Advantage Plan, I may be subject to a Late Enrollment Penalty if I later choose to enroll in another Medicare Part D prescription drug plan depending on how long there is a gap in my prescription drug coverage.

I understand that I can only be enrolled in one Medicare Advantage plan or Medicare Part D prescription drug plan at a time.

I certify that I have completely read and fully understand the terms and conditions of submitting this form. I also attest that all representations made by me on this form are true and correct.

Signature:______________________________ Date: ____________________

Printed Name: ____________________________ Relationship: ____________________

If signed as a Personal Representative, you must provide documentation of your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (e.g., Parent, Power of Attorney, Guardianship, or Conservatorship).

State Employees' Insurance Board
201 South Union Street, Suite 200 • Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: (334) 263-8341 • Toll Free: 1-866-836-9737 • Fax: (334) 263-8541
SEIBEnrollments@alseib.org • www.alseib.org