

## Tufts Health Plan Medicare Preferred EG Disenrollment Request Form

If you request disenrollment, you will continue to receive all medical care from Tufts Health Plan Medicare Preferred until the effective date of disenrollment.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Member Identification Number(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Requested Term Date: \_\_\_\_\_

Each Member must sign and date the form. The term date must be the last day of the month. The form must be signed and dated prior to the term date.

