TUFTS Health Plan

Corporate Office
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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.