# Blue Cross® Medicare Supplement & Legacy$^{5}_{M}$ 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 number from your Blue Cross card. |
|---|---|

| Birth date | Sex ☐M ☐F | Home phone number ( ) |
|---|---|---|

**Please check the box below:**

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

**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 won't be able to reenroll 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
Mail Code J200
P.O. Box 44407
Detroit, MI 48244-0407

You can also disenroll by calling Customer Service at 1-888-216-4858.