Enter the name of the individual opting out.

Found on your current State of Michigan BCBS ID card.

Found on the current Medicare ID card of the person opting out.

MA Medicare H

…age, com… to Blue Cross. I…

Name of contract holder	
BCBSM contract no.	**Medicare ID no.**

Important: *You can only be enrolled in one Medicare Advantage plan at a time. If you are already enrolled in an individual Medic… e Advantage, you must decide which plan you … lled in another plan, we will enroll you in St… omatically cancel your other Medicare he…*

A person opting out is eligible to remain in the Supplemental State Health Plan PPO by checking this box, if you have other primary coverage. They must include proof of other primary coverage (e.g., copy of primary insurance ID card).

❑ **I decline Medicare Advantage coverage for myself (the contract holder) and understand this will result in cancellation of all health benefits for me and all dependents currently covered by State Health Plan MA.**

❑ **I want to join State Health Plan MA's Medicare Advantage plan, but wish to remove the following Medicare-eligible dependents from my contract.**

Dependent's last name	Dependent's first name	Date of birth	Dependent's signature
			X
			X
			X
			X

The individual opting out must complete all three fields in this section (signature, date, and daytime phone number).

Once you or your representative have chec… ormation, please complete the information below, sign, and date.

X_____ _____

Contract holder's signature **Date**

(___) _____

Daytime phone no.

If you are signing as the contract holder's authorized representative, please complete the section below.

The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this opt-out form and 2) documentation of this authority is available upon request.

Name of representative	**Daytime phone no.**
Address	**Relationship to retiree**

FOR OFFICE USE ONLY					
ORS Rec'd date:		Confirm date		ORS Rep name	
Please check one	❑ Opt-out confirmed ❑ Opt-out reversed (Member will be enrolled) ❑ Enroll co… ❑ Other ___				
Comments:					

In the *Comments* box, write in "See included proof of other primary coverage".