P.O. Box 9178
Watertown, MA 02472

DELTA DENTAL® OPTION DISENROLLMENT FORM

This Disenrollment Form may be used by members to disenroll from the Delta Dental Option.

To disenroll from the Delta Dental Option, please provide the following information:

Member ID: ______________________________ Birth Date: __________________________________

Last Name: ______________________________ First Name: __________________________ MI: ___

Permanent Residence Address: ____

City: _____________________________________ State: ___________________ Zip Code: _________

County: __________________________________ Home Phone Number: (_____) ________________

Mailing Address *(only if different from your Permanent Residence Address)*

Mailing Address: ____

City: _____________________________________ State: ___________________ Zip Code: _________

Please read the following information before signing and dating this disenrollment form:

I hereby request disenrollment from the Delta Dental Option, administered by Delta Dental of Massachusetts. I understand that this disenrollment will be effective on the first of the month after Tufts Health Plan Medicare Preferred receives my signed and completed disenrollment request.

By signing below, I am requesting to disenroll from the Delta Dental Option and acknowledge that I will remain a member of Tufts Medicare Preferred HMO Plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this disenrollment form means that I have read and understand the contents of this disenrollment form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

SIGNATURE: ____ **DATE:** _____________________

If you are the authorized representative, you must sign above and provide the following information:

Name: ____

Address: ____

Phone Number: (______) ___________________ Relationship to Enrollee: ______________________

Please continue to page 2 for additional information.

H2256_2016_124 Approved

Please mail this completed form to:

Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9178
Watertown, MA 02471-9948

For More Information:

Please contact Customer Relations at 1-800-701-9000 (TTY: 1-800-208-9562) with any questions. Representatives are available Monday - Friday, 8 a.m. to 8p.m. (From October 1 – February 14, representatives are available 7 days a week, 8 a.m. to 8 p.m.) After hours and on holidays, please leave a message, and a representative will return your call on the next business day.

Tufts Health Plan Medicare Preferred is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan Medicare Preferred depends on contract renewal.

You must continue to pay your Medicare Part B premium.

Delta Dental of Massachusetts is an Independent Licensee of the Delta Dental Plans Association. The Delta Dental Option is administered by Delta Dental of Massachusetts. ®Registered Marks of the Delta Dental Plans Association.

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