



NDPERS PRESCRIPTION DRUG PLAN (PDP) DISENROLLMENT FORM
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58861 (Rev. 11-2015)

**NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

Disenrollment Instructions:

Before you make your decision, please examine all your options to be sure you understand the plan coverages, eligibility and enrollment opportunities for other coverage. By cancelling your prescription drug plan coverage, you will no longer be able to participate in the NDPERS Dakota Retiree Plan medical coverage.

If you wish to disenroll from the NDPERS Prescription Drug Plan (PDP) provided through Express Scripts Inc (ESI), please carefully read and complete all sections on this form and submit to NDPERS along with a Request to Cancel Retiree Health Insurance Coverage SFN 58269 by the end of the month **prior to** the disenrollment effective date. I understand that the form must be signed in the month prior to the requested disenrollment date.

PART A MEMBER INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (MO/DAY/YR)

Medicare Claim Number _ _ _ _ - _ _ _ - _ _ _ _ - _ _

PART B MEDICARE PDP DISENROLLMENT AGREEMENT & AUTHORIZATION

By completing this Medicare PDP disenrollment request, I agree to the following:

I understand that until my disenrollment is effective, I must continue to fill my prescriptions through Express Scripts, Inc. network pharmacies in order to receive my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare prescription drug plans, unless I qualify for special circumstances.

I understand that I am disenrolling from my NDPERS Prescription Drug Plan (PDP) and, if I do not enroll in another Medicare Prescription Drug Plan or a Medicare Advantage with a Prescription Drug Plan at this time, or have other coverage as good as Medicare, I may have to pay a penalty for this coverage in the future.

I understand that by disenrolling from the NDPERS Prescription Drug Plan (PDP), I will no longer be able to participate in the NDPERS Dakota Retiree Plan for medical coverage.

Please mark the box next to the reason(s) that applies to why you are disenrolling from the NDPERS Prescription Drug Plan (PDP) Coverage:

<input checked="" type="checkbox"/>	Due to loss of Medicare
<input type="checkbox"/>	I no longer live within the service area
<input type="checkbox"/>	Enrolled in another Medicare Prescription Drug Plan: Enrollment Date ____/____/____
<input type="checkbox"/>	I have other coverage equal to the Medicare Prescription Drug Coverage: Enrollment Date ____/____/____
<input type="checkbox"/>	Other (Please Specify):

Requested Disenrollment Date: _____

Member Signature: _____ Date: _____