THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Humana Group Medicare Advantage PPO and Prescription Drug Plan (PDP) Waiver or Withdrawal

Personal information		
Name *(first, middle, last)*		Last four digits of SSN
Mailing address		
Street address *(if different from mailing address)*		
City	State	ZIP
Phone	Email	
If you are not the member, complete:		
Member's name *(first, middle, last)*		Last four digits of SSN

Application for waiver of coverage

Complete if you do not wish to be enrolled in the Humana Group Medicare Advantage PPO plan and Prescription Drug Plan (PDP).

I am applying for a waiver of the Humana Group Medicare Advantage PPO plan and PDP available through the Board of Pensions.

Effective date of waiver* (mm/dd/yyyy)

I wish to waive medical coverage for myself. ☐ Yes ☐ No

I wish to waive medical coverage for my spouse. ☐ Yes ☐ No

Withdraw from Humana Group Medicare Advantage PPO and Prescription Drug Plan (PDP)

Complete if you are currently enrolled in the Humana Group Medicare Advantage PPO plan and the Prescription Drug Plan (PDP) and you wish to withdraw from coverage.

I/we withdraw from the Humana Group Medicare Advantage PPO plan and PDP. If withdrawing because I/we are enrolling in a different Medicare Advantage plan, supplemental coverage (such as a Medigap plan), or TRICARE, I/we understand that completing this form only withdraws us from the Humana Group Medicare Advantage PPO plan and PDP; it does not enroll us in a different Medicare Advantage plan, supplemental coverage (such as a Medigap plan), or TRICARE. To enroll, I/we must contact that organization directly.

Coverage withdrawal date* *(mm/dd/yyyy)*

I wish to withdraw myself from the Humana Group Medicare Advantage PPO plan and the Prescription Drug Plan (PDP).

☐ Yes ☐ No

I wish to withdraw my spouse from the Humana Group Medicare Advantage PPO plan and the Prescription Drug Plan (PDP).

☐ Yes ☐ No

*This is the last day you will be covered under the Board's active Medical Plan, medical continuation coverage, or the Humana Group Medicare Advantage PPO plan and PDP. Because coverage is offered in monthly segments, the end date must be the last day of the month before you join a different Medicare Advantage plan, a supplemental plan (such as a Medigap plan), or TRICARE.

Mail, fax, or email this completed form to: The Board of Pensions of the Presbyterian Church (U.S.A.)

Mail to:	**Fax to:**	**Email to:**
2000 Market Street Philadelphia, PA 19103-3298	215-587-6215	memberservices@pensions.org

THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Humana Group Medicare Advantage PPO and Prescription Drug Plan (PDP) Waiver or Withdrawal

Authorization

Waiver of coverage

I/we understand and accept that:

- If the Board of Pensions approves this application for waiver of coverage, I/we will have no medical or prescription drug coverage through the Board during the effective term of this waiver.

I/we also understand that I/we must apply for coverage within 60 days of the qualifying event.

I/we hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

Withdraw from Humana Group Medicare Advantage PPO and Prescription Drug Plan (PDP)

I/we authorize the Board of Pensions to end my/our participation in the Humana Group Medicare Advantage PPO plan and the Prescription Drug Plan (PDP).

I/we also understand that I/we must apply for coverage within 60 days of the qualifying event.

Signature of member/subscriber *(required)*	Date *(mm/dd/yyyy)*
Signature of spouse *(if applicable)*	Date *(mm/dd/yyyy)*

Mail, fax, or email this completed form to: The Board of Pensions of the Presbyterian Church (U.S.A.)

Mail to:	**Fax to:**	**Email to:**
2000 Market Street Philadelphia, PA 19103-3298	215-587-6215	memberservices@pensions.org