ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

2023 PHARMACY DRUG PLAN (PDP) DISENROLLMENT FORM

ARIZONA DEPARTMENT OF ADMINISTRATION (ADOA) HR-BENEFITS

Section 1: Member Information

LAST NAME		FIRST NAME	M.I.
EMPLOYEE ID NUMBER (EIN)	BIRTH DATE	❑ FEMALE ❑ MALE	
HOME PHONE	CELL PHONE	EMAIL	

Section 2: Instructions to Disenroll

- Please fill out and carefully read all information below before completing and returning this disenrollment form for the VibrantRx PDP.
- Alternative Disenrollment Method: Instead of returning this form, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

Section 3: Acknowledgements and Signatures

By completing this disenrollment request, I agree to the following:
(Check each box)

- ❑ My disenrollment date is stated on the communication that accompanies this form.
- ❑ I understand that until my disenrollment is effective, I must continue to fill my prescriptions at VibrantRx PDP network pharmacies to get coverage.
- ❑ I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances.
- ❑ I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

MEMBER SIGNATURE: ______________________ **Date:** ______________

MEMBER NAME (PRINT): ______________________

DEPENDENT/SPOUSE SIGNATURE: ______________________ **Date:** ______________

DEPENDENT/SPOUSE NAME (PRINT): ______________________

(Any spouse/dependent with Medicare coverage with ADOA medical MUST sign; electronic signatures are not accepted)

Section 4: Authorized Representative

In lieu of the member's signature, the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides may be used. If signed by an authorized individual meeting the legal requirements, 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 Medicare.

AUTHORIZED REPRESENTATIVE SIGNATURE	DATE	AUTORIZED REPRESENTATIVE NAME (PRINT)
ADDRESS, CITY, STATE, ZIP		PHONE NUMBER
RELATIONSHIP TO MEMBER		EMAIL

RETURN TO: ARIZONA DEPARTMENT OF ADMINISTRATION (ADOA), HR-BENEFITS, 1802 W JACKSON ST, #94, PHOENIX, AZ 85007
FAX: 602-542-4744 | EMAIL: BENEFITS@AZDOA.GOV | PHONE: 602-542-5008 | TOLL-FREE: 800-304-3687