BlueCross BlueShield
Federal Employee Program®

FEP Medicare Prescription Drug Program Disenrollment Form for Postal Service Health Benefits (PSHB) Program Members

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your disenrollment date after we get this form from you.

First Name:	Last Name:	Middle Initial:
Birth Date:	Member ID Number:	Phone Number: ( )

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

The FEP Medicare Prescription Drug Program (MPDP) will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I should continue to use my current Blue Cross and Blue Shield Federal Employee Program (FEP) member ID card for coverage. I understand that I am disenrolling from my Medicare Prescription Drug Plan and **I will no longer have FEP prescription drug coverage.**

Signature* _____ Date: _____

**Or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides. If signed by an authorized individual (as described above), 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.*

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

Name: _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee: _____

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