PARAMOUNT
Insurance Company

Paramount Medicare Part D Prescription Drug Plan Disenrollment Form

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

Last Name: First Name: Middle Initial:		Mr. Mrs. Miss Ms.
Member ID:	**Paramount PDP #**	
Birth Date:	Sex: M F	Home Phone Number: ( )

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

- I have provided a **prospective notice** to the above member regarding termination from Paramount PDP Plan. This notice was provided at least 21 calendar days prior to the disenrollment effective date.
- As the employer, I have also informed the above member of other insurance options that may be available to the member.
- Paramount Prescription Drug Plan will notify me of the disenrollment date after receipt and review of this form.

Employer Representative Signature _____Date: _____

Employer Phone #: _____ E-Mail: _____

Office Use Only: Enrollment Coordinator Medicare Programs

Disenrollment Effective Date: _____

Election Type: € AEP € SEP

Signature: _____ Date: _____