Blue Shield of California Optional Supplemental Dental HMO or Optional Supplemental Dental In-Network Only (INO) Plan Disenrollment Request Form

You can disenroll from the Optional Supplemental Dental HMO or Optional Supplemental Dental In-Network Only (INO) plan at any time. Disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for their Optional Supplemental Dental HMO or Optional Supplemental Dental In-Network Only (INO) plan premium payment if the disenrollment request is received after the last day of the month.

Please contact Blue Shield of California if you need information in another language or format (braille).

Please send your completed disenrollment form to:
Email: WHMembership@blueshieldca.com
Mail: Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856
Fax: (877) 251-3660

Member number:

Last name:	First name:	Middle initial:
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	

Home phone number:

Please carefully read and complete the following information before signing and dating this disenrollment form:

Submitting this form to disenroll from the Optional Supplemental Dental HMO or Optional Supplemental Dental In-Network Only (INO) plan will NOT result in disenrollment from your Blue Shield of California Medicare Advantage Plan.

If you want to disenroll from your Blue Shield of California Medicare Advantage Plan, contact us at the number on your ID card for a copy of that disenrollment form.
Please note that you may only disenroll during certain times of the year. For more information, please contact the plan.

Your signature:*	**Today's date (MM/DD/YYYY):**

*Or the signature of the person authorized to act on your behalf under the laws of the state where you live. 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 Blue Shield of California or by Medicare.

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

Last name:	First name:	Middle initial:
Street address:		
City:	State:	ZIP code:
Phone number:		
Relationship to enrollee:		