

Request to Cancel Medicare Part B (Medical Insurance)

If you don't want Medicare Part B (Medical Insurance),
complete this form and return it before: _____

I don't want Part B

★ **TRICARE enrollees (Military Health Benefits):**
Read the Important Notice on the back if you
have other coverage BEFORE you decline Part B

Wage earner's name (if different from yours)			Social Security Claim Number	
Your name			Signature (Do not print)	Date signed
Mailing address (Number and street, PO Box, or route)			Only signature by mark (X) must be witnessed:	
			Signature of witness	Date signed
City	State	ZIP code	Address of witness	

Medicare Part B (Medical Insurance) is automatically included in your Medicare coverage unless you choose to decline it. If you wish to decline Part B coverage, you must complete and return this form by the date indicated above. If you take no action, you will be enrolled in Medicare Part B.

Medicare Part B will help you pay your doctor bills and bills for many other medical items and services not covered under Medicare Part A (Hospital Insurance). Unless you already have broad protection against medical costs, you will probably benefit by keeping this Medicare protection.

Important Notice about Medicare Part B and Other Health Coverage: If you have other health insurance coverage, such as TRICARE or certain employer or government plans, you may be required to enroll in Medicare Part B to keep those benefits. Failing to enroll in Medicare Part B when required could lead to the loss of your health coverage, higher premiums if you decide to enroll in Part B later, or gaps in your overall health coverage.

Paperwork Reduction Act: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average X minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn.: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **DO NOT MAIL YOUR COMPLETED FORM TO THIS ADDRESS. If you do, we won't be able to process your form, and your request to release your personal health information will be significantly delayed.**