	Check box(s) below if applicable	
	Applicant A	**Applicant B**
(g) Please indicate reason for termination/disenrollment:		
■ Your Medicare Advantage plan is leaving the Medicare program	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan	☐	☐

■ Other: ______________________
Applicant A
____
Applicant B

Please answer questions regarding other health insurance:

	Applicant A	**Applicant B**
6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☑ Y ☐ N	☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank

Applicant A	START	01/01/2019
	END	__/__/____
Applicant B	START	__/__/____
	END	__/__/____

(b) Planned date of termination/disenrollment?

Applicant A	05/31/2024
Applicant B	__/__/____

	Applicant A	**Applicant B**
(c) Have you disenrolled from your current coverage voluntarily?	☑ Y ☐ N	☐ Y ☐ N

(d) Please state the reason for your disenrollment:

Starting Medicare
Applicant A
____
Applicant B

(e) With what company and what kind of policy/certificate? (List below.)

Applicant A N. Hristova 5-8-24	**Applicant B**
Name of Company ~~UMPC~~ UPMC	Name of Company
Policy/Certificate type Employer Group Health	Policy/Certificate type

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

	Applicant A	**Applicant B**
7. Are you applying during an open enrollment period?		
(a) Did you turn age 65 in the last six months?	☑ Y ☐ N	☐ Y ☐ N
(b) Did you enroll in Medicare Part B in the last six months?	☐ Y ☑ N	☐ Y ☐ N

If either question 7a or 7b is "YES", indicate your Medicare Part B effective date Applicant A __/__/____
Applicant B __/__/____

8. Are you applying during a guaranteed issue period? (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☑ N	☐ Y ☐ N

IF YOU ANSWER "YES" TO BOTH QUESTIONS 7A AND 7B OR QUESTION 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.