U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0025
Expires: 08/31/2027

Request for Termination of Medicare Premium Part A, Part B, or Part B Immunosuppressive Drug Coverage (Part B-ID)

Use this form to request to end your Medicare coverage. You can terminate Part A only if you pay a premium for it. You can terminate Part B or Part B-ID at any time.

Enrollee first name | Middle name | Last name | Suffix

Medicare Number
____-____-____

Mailing address

City | State | ZIP code

Phone number
(___)___-____

Email address

Name of person completing this form (if not the enrollee)

This is a request to end my:

☐ **Part A (Hospital Insurance)**

☐ **Part B (Medical Insurance)**

☐ I understand that ending Part B will also terminate my Part A if I pay a premium for Part A.

Note: Your Part A/Part B coverage will end the last day of the month **AFTER** the month you submit your request. For example, if you submit your request April 5, your coverage will end May 31.

☐ **Part B-ID**

Enter the month and year you want coverage to end:
__/____

Note: Your Part B-ID coverage will end the last day of the month you request. For example, if you ask for coverage to end in April, your last day of coverage will be April 30.

I want to end my Medicare coverage for these reasons (optional):

Signature | **Date signed (mm/dd/yyyy)**
__/__/____

If this form has been signed by mark (X), a witness who knows the person applying must also sign below:

Name of witness (first and last name)

Signature of witness | Date signed (mm/dd/yyyy)
__/__/____

Important! If you change your mind about ending your coverage, you must contact SSA before your coverage end date.

Submit your form by mail or fax

Mail or fax your completed, signed form to your local Social Security office. Find an office near you at SSA.gov/locator.

Section 1838(b) and 1818A(c)(2)(B) of the Social Security Act require filing of notice advising the Administration when termination of Medicare coverage is requested.

Privacy Act Statement: Social Security is authorized to collect your information under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii) for your enrollment in Medicare Part B. Social Security and the Centers for Medicare & Medicaid Services (CMS) need your information to determine if you're entitled to Part B. While you don't have to give your information, failure to give all or part of the information requested on this form could delay your application for enrollment.

Social Security and CMS will use your information to enroll you in Part B. Your information may be also be used to administer Social Security or CMS programs or other programs that coordinate with Social Security or CMS and in accordance with System of Records Notice (SORN) "HHS/CMS/CBC Enrollment Database", System No. 09-70-0502, 73 Federal Register 10249, February 26th, 2008 and as permitted by the Privacy Act of 1974, to 1) Determine your rights to Social Security benefits and/or Medicare coverage. 2) Comply with Federal laws requiring Social Security and CMS records (like to the Government Accountability Office and the Veterans Administration). 3) Assist with research and audit activities necessary to protect integrity and improve Social Security and CMS programs (like to the Bureau of the Census and contractors of Social Security and CMS). We may verify your information using computer matches that help administer Social Security and CMS programs in accordance with the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

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 0938-0025. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.