MEDICAL MUTUAL®

MedMutual Advantage Address Change Form

Please use this form to request an address change. If your move affects your eligibility to remain in your current plan, we will notify you within two weeks of your request.

Please note: Items marked with an asterisk (*) are required.

Member Information	
Last Name*	First Name*
Member ID Number*	Phone Number ( )

New Address/Move Information		
Today's Date*	Date of Move*	Check all that apply: ☐ I have already moved. ☐ This is a future move. ☐ This is a change to my mailing address only. My permanent residence remains the same.

This move is:

☐ **Permanent**

Note: If you are moving to one of the following counties or outside of Ohio, you will be disenrolled: Ashtabula, Athens, Belmont, Gallia, Jefferson, Meigs, Muskingum, Tuscarawas. Typically, your disenrollment is effective the end of the month of your move.

If your move is in the past, you may request to be disenrolled back to the month of your move. Would you like to do this? ☐ Yes ☐ No

If you choose a retroactive disenrollment date, it is in your best interest to have creditable prescription drug coverage for the period after your disenrollment from Medical Mutual. **Please note:** If you do not have creditable prescription drug coverage for more than 63 days, you may have to pay a late enrollment penalty for as long as you have Medicare. Visit Medicare.gov for more information about creditable coverage and the late enrollment penalty.

☐ **Temporary**

Note: For temporary moves, please call the Customer Care number on your member ID card to let us know when you return. That way, we can update your records to your permanent address. Or if you prefer, you can complete this form again to notify us.

New Street Address*	
City*	State*
County*	ZIP Code*

Signature		
I authorize Medical Mutual to send my plan materials to the address listed above. This address will continue to be used until I notify Medical Mutual of a change, including a return to my permanent address.		
Member Signature*	Date*	
If you are an authorized representative, please sign below.		
Signature of Authorized Representative	Relationship ☐ Legal Guardian ☐ Power of Attorney	Date

Please send the signed and completed form to:

Medical Mutual
P.O. Box 94563
Cleveland, OH 44101