COMMUNITY Health Options™

# 10-Day Agreement Review Cancellation

This form is used to request a policy cancellation according the terms of the Member Benefit Agreement. This form must be filled out completely and signed by the Subscriber in order to properly process the cancellation request. Members that signed up through the Federally-Facilitated Marketplace (Healthcare.gov) will have to process termination through the Marketplace, in addition to completing and submitting this form.

| SUBSCRIBER INFORMATION | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **M.I.** | **Member ID#** |
| | | | |
| **Mailing Address** | | | **Date of Birth** (MM/DD/YYYY) |
| | | | / / |
| **City** | **State** | **Zip Code** | |
| | | | |

Under the terms of the Member Benefit Agreement, a Subscriber has the right to request to cancel the Agreement within 10-days of the effective date of coverage, (also known as the "free look period"). If the Subscriber chooses to take advantage of the free look period, then the coverage is rescinded and treated as if the Subscriber NEVER had coverage. Any claims during the "free look period" will be applied toward the premium refund. If claims exceed the premium refund amount, the Subscriber will be balance billed any remaining claims balance. If a cancellation under the terms of the 10-Day Agreement Review is requested, please check the box below:

☐ As the Subscriber, I am requesting cancellation and refund of any premiums under the terms of the 10-Day Agreement Review, as explained in the Member Benefit Agreement. I understand that this request, if approved, means that the policy is rescinded and any claims are the Subscriber's responsibility. Community Health Options (Health Options) is not responsible for any claims that may be related to the policy and this action is not reversible.

| ATTESTATION AND SIGNATURE | | |
|---|---|---|
| I attest that the above information is true and accurate. I understand that any claims incurred after cancellation of this policy are not the responsibility of Community Health Options. For consumers that used the Federally-Facilitated Marketplace (FFM), I understand that I may have further responsibilities to cancel my policy through the FFM and Health Options will not fully process this cancellation until it receives confirmation of cancellation of policy from the FFM. I understand that a Special Enrollment Period (SEP) may be required for retroactive policy terminations and that SEP must be obtained from the FFM. | | |
| **Print Name** | **Subscriber Signature** | **Date** |
| | | / / |

Mail this completed form to: Enrollment and Eligibility, Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243. Or, Fax to: Community Health Options, (207-402-3745), Attn: Enrollment and Eligibility. Or, email a scanned copy to: Enrollment@HealthOptions.org . If you have questions, call Member Services (855-624-6463).