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**	
		/ /	
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 If the Subscriber chooses to take advantage of the free look period, then the coverage is rescinded and treated as if the Subscriber NEVER had coverage.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 I understand that this request, if approved, means that the policy is rescinded and any claims are the Subscriber's responsibility.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).

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at Compliance@HealthOptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
  - Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-624-6463 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-624-6463 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-624-6463 (TTY/TDD: 711)	**Arabic** ة ظوحلم: اذإ ت نك ثد حتت ر كذا ة غللا، نإ ف تامدخ ةدعا سملا و غللاية ر فاوتت ك ل نا جملاب. ل صتا مقر ب 1-855-624-6463 م قر م كبلاو م صلا ه: TTY/TDD 711.
Cambodian, Mon-Khmer ប្រយ័ត៖ បើសិន អ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែក ភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-624-6463 (TTY/TDD: 711)។	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-624-6463 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-624-6463 (TTY/TDD: 711).	**Thai** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-624-6463 (TTY/TDD: 711).	**Nilotic-Dinka** PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-624-6463 (TTY/TDD: 711)번으로 전화해 주십시오.	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-624-6463 (TTY/TDD: 711).	**Japanese** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-624-6463（TTY/TDD: 711）まで、お電話にてご連絡ください。

CONFIDENTIALITY NOTICE: This communication and its information is intended only for the use of the individual to which it is addressed. If you have received this communication in error, please notify us immediately at 855.624.6463. This communication and its information may be protected by federal and/or state privacy and mental health/substance abuse confidentiality rules including but not limited to HIPAA and 42 CFR Part 2. You are hereby notified that any disclosure, dissemination, distribution or copying of this communication or its information is strictly prohibited unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.