CANCELATION/DISCONTINUATION OF COVERAGE:
IMPORTANT NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

NAME: ____ DATE: _________________
(Employee – please print)

This is to confirm my decision to discontinue enrollment in the organizations group health and/or voluntary coverages (check all that apply) as of _____________:
(**Last day of month**)

I have been enrolled in the group medical and/or dental plans offered by Janus Youth Programs and have elected to discontinue such coverage as follows (check those applicable):

______Medical coverage:___ For Self ______For Spouse/Partner ______For Dependent Child(ren)

______Dental coverage: ___ For Self ______For Spouse/Partner ______For Dependent Child(ren)

Reason: ____

I have elected to discontinue my voluntary coverages, provided by Colonial Life (Short-Term Disability, Critical Care Illness, Medical Bridge, and Accident Coverage); PacificSource (Medical, Childcare and/or Transportation Flexible Spending Account) and/or Unum Voluntary Life coverages:

If applicable:_______ Colonial Life*______ Voluntary Life Coverages* ______ Flexible Spending Account*

*May need to complete an additional form to terminate or change coverage under a voluntary plan.

I understand that if I later want to enroll I may be denied coverage or may be subject to late enrollment restrictions. I understand these same restrictions apply to dependents, spouse and/or domestic partner if I do not enroll them during my initial eligibility. I understand that these restrictions and/or denials do not apply if my declination of coverage is due to having other coverage and I understand that I may be required to provide documentation of having had such other coverage.

Special Enrollment Rights under HIPPA:

I understand that if I do experience a loss of other coverage and want to enroll in group coverage I must do so within 30 days of other coverage ending. Loss of other health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

Effective April 1, 2009, I understand that if I or my spouse, domestic partner or eligible dependent child lose eligibility for State CHIP (Children's Health Insurance Program) assistance or Medicaid coverage or if I or my spouse, domestic partner or dependent become eligible for State CHIP assistance or Medicaid coverage, I may be able to enroll myself and/or my dependents/spouse or domestic partner in the group health plan. To do so I must submit a request for coverage within 60 days of the qualifying event (eligibility or loss of eligibility).

In addition, I understand that if I have a change in family status, I may be able to enroll myself or my spouse or my dependent child(ren) in the group medical coverage, provided that I request enrollment within 30 days of the change in family status. Change in family status includes marriage, birth, adoption or placement for adoption. I understand that if I or my dependent spouse are not enrolled for this coverage, we can also enroll during the special enrollment period when a change in family status occurs although we may be subject to preexisting condition exclusion/limitation or enrollment limitations. I understand that since I am electing not to participate in the organization's group medical and/or dental coverage I will not qualify for Continuation of Group Coverage under the COBRA law at the time of employment termination.

My signature below indicates that I release my employer and the Plan Administrator, from any liability that could arise concerning my health care, dental care, and/or voluntary coverages as a result of my discontinuing coverage.

______________________________ ____________

Employee Signature Date

cc: Personnel File
Payroll