

**ATTACHMENT E**

**LETTER OF INTEREST FOR QUALIFIED HEALTH PLAN, STAND-ALONE DENTAL, ESSENTIAL PLAN AND SHOP PLAN PARTICIPATION IN THE NY STATE OF HEALTH**

**Please indicate the plans you are interested in participating in for 2024:**

**QHP Market(s): Individual** [ ]  **SHOP** [ ]  **Both Individual/SHOP** [ ]

**SADP Market(s): Individual** [ ]  **SHOP** [ ]  **Both Individual/SHOP** [ ]

**Essential Plan:** [ ]

The following form should be completed and returned to the Authorized Contact person no later than the time set forth in the Invitation.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, an authorized representative of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Applicant, have read the Invitation and Requirements for Application or Recertification for Participation in the NY State of Health (Marketplace) and I am submitting this Letter of Interest to participate in the Marketplace for calendar years 2024 on behalf of Applicant.

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| --- |
| Name: |
| Title: |
| Company: |
| Address: |
| Telephone: |
| E-mail Address: |
| Date: |
| Signature: |

Check this box if you would like notification of schedule changes, updates and other modifications of the Invitation to Participate in the NY State of Health sent to the above e-mail address.