

## Assistance with Your Application

### You can choose an authorized representative.

You can give a trusted friend, relative, partner, or attorney permission to talk with us about your application and act for you on matters related to your account. This person is called an “authorized representative. “

An authorized representative can:

- Sign your application;
- Help you with redeterminations and renewals;
- Receive copies of notices and other communications;
- Request appeals; and
- Act on your behalf in all other matters with NY State of Health: The Official Health Plan Marketplace.

You should complete this form if:

- You want to name someone as your authorized representative for the first time; or
- You want to change the authorized representative you named at any other time.

If you already have a legal document that authorizes someone to act for you under New York State law, the Marketplace can accept a copy of that document in place of the authorized representative form. Examples of documents that we accept for this purpose are a court order establishing guardianship or a power of attorney form.

Before we can speak with or release information to an authorized representative, we need to verify his or her identity. Your authorized representative can verify his or her identity by completing the **Authorized Representative Identity Verification Form**. If you need to request a copy of this form, please call 1-855-355-5777.

To authorize someone to act as your representative, fill out the form below or provide documents showing that you already have a legally appointed representative. Then return it, along with the Authorized Representative Identity Verification Form and the documents proving identity to the NY State of Health at P.O. Box 11727, Albany, NY 12211. Or fax it to 1-855-900-5557.

NEED HELP WITH THIS FORM? Call us at 1-855-355-5777.  
TTY users should call 1-800-662-1220 or 1-877-662-4886 for TTY in Spanish.

## Authorized Representative Designation Form

Applicant or Enrollee's name (First name, Last name)		
Mailing address		
City	State	ZIP code
Telephone Number	SSN	Date of Birth (mm/dd/yyyy)

### CHECK ONE

The person or organization below is my authorized representative for **all matters** related to my account.

The person or organization below is my authorized representative only to **act as my representative during an appeal.**

By signing, you allow this person or organization to get official information about your account and act for you for the matters you stated above. Your authorization will become effective when we receive this completed form, and it will remain effective until you or your authorized representative tell us that the authorization has ended.

Applicant or Enrollee's signature	Date (mm/dd/yyyy)
-----------------------------------	-------------------

## Acceptance of Designation

Authorized representative's name (First name, Last name, or Organization name)		
Mailing address		
City	State	ZIP code
Telephone number	<input type="checkbox"/> Attorney <input type="checkbox"/> Non-attorney representative	

By signing, you agree to maintain the confidentiality of any information regarding the applicant or enrollee that NY State of Health provides. You also agree to fulfill all the responsibilities encompassed within the scope of this authorization as if you were the applicant or enrollee. You also agree to comply with applicable state and federal laws concerning conflicts of interest.

If you are signing on behalf of an organization, you agree that providers, staff members, and volunteers affirm that they will comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Representative's Signature	Date (mm/dd/yyyy)
----------------------------	-------------------

NEED HELP WITH THIS FORM? Call us at 1-855-355-5777.  
TTY users should call 1-800-662-1220 or 1-877-662-4886 for TTY in Spanish.

## Verifying an Authorized Representative's Identity

### We will verify an authorized representative's identity by reviewing documents

NY State of Health needs to verify your identity to allow you to act as someone's authorized representative. You need to complete the form below and submit **copies** of the necessary documents. Please do not send originals. Once we verify your identity, you can act on the applicant's behalf in applying or reapplying for health insurance coverage or in carrying out other ongoing communications with the Marketplace.

Please complete the top portion (1 – 6) about yourself and the middle portion (7 – 14) about the applicant who designated you as an authorized representative. It is important that you complete these sections accurately. Finally, you must sign and date (15 – 16) the Authorized Representative Identity Verification Form.

### Documents that prove your identity

You must submit copies of identity proving documents along with your completed form. These must be your documents and **not** the documents of the applicant who named you as a representative. They could include your driver's license, United States passport, or birth certificate. You will find a complete list of approved documents on the form.

There are two categories of approved documents. If you submit a copy of a document from List A, it should have your photograph or a physical description of you, including information such as your name, age, sex, race, height, weight, and eye color. If you do not have a document from List A, you can send copies of **two** documents from List B. The information on both documents from List B must match.

Once you have completely filled out the form and collected copies of the documents listed below, you can mail them to: NY State of Health, PO BOX 11727, Albany, NY 12211. You can also fax them to 1-855-900-5557.

NEED HELP WITH THIS FORM? Call us at 1-855-355-5777.  
TTY users should call 1-800-662-1220 or 1-877-662-4886 for TTY in Spanish.

## Authorized Representative Identity Verification Form

1. Authorized Representative Name			
2. Address		3. City	
4. State	5. ZIP Code	6. Telephone Number	
7. Applicant Name			
8. Applicant Address		9. City	10. State
			11. ZIP Code
12. Applicant Date of Birth (mm/dd/yyyy)		13. Applicant Social Security Number	14. Applicant Telephone Number
Submit a <b>copy</b> of <b>ONE</b> document from List A		<b>OR</b>	Submit one <b>copy</b> of <b>TWO</b> documents from List B
<ul style="list-style-type: none"> <li>• U.S. Passport book or card</li> <li>• Driver's license</li> <li>• Official Government Identification card</li> <li>• School Identification card</li> <li>• U.S. military card or draft record</li> <li>• Military dependent's Identification card</li> <li>• Native American Tribal Document</li> <li>• U.S. Coast Guard Merchant Mariner card</li> <li>• Certificate of Naturalization (N-550 or N-570)</li> <li>• Certificate of U.S. Citizenship (N-560 or N-561)</li> </ul>			<ul style="list-style-type: none"> <li>• Birth certificate</li> <li>• Social Security card</li> <li>• Marriage certificate</li> <li>• Divorce decree</li> <li>• Employer Identification card</li> <li>• High school diploma</li> <li>• College diploma</li> <li>• High school equivalency diploma</li> <li>• Property deed or title</li> </ul>
<p><b>Attestation.</b> I attest, under penalty of perjury, that to the best of my knowledge the information in and submitted with this form is true and correct.</p>			
15. Authorized Representative Signature			16. Date (mm/dd/yyyy)

NEED HELP WITH THIS FORM? Call us at 1-855-355-5777.  
 TTY users should call 1-800-662-1220 or 1-877-662-4886 for TTY in Spanish.