ATTACHMENT D
LETTER OF INTEREST TO PARTICIPATE IN THE NEW YORK HEALTH BENEFIT EXCHANGE

The following form should be completed and returned to the Authorized Contact person no later than February 15, 2013.

I, _____, an authorized representative of

_____, Applicant, have read the Invitation to Participate in the New York Health Benefit Exchange and I am submitting this Letter of Interest to Participate in the New York Health Benefit Exchange for calendar years 2014 and 2015 on behalf of Applicant.

The Applicant intends to apply for participation in the following Exchange(s):

A. PARTICIPANT TYPE

- ☐ Health Insurer Applicant
- ☐ Stand-Alone Dental Applicant
- ☐ CO-OP

MARKET

- ☐ Individual
- ☐ SHOP

B. ENTITY APPLYING

Identify the entity that will apply for participation and its applicable licensure (e.g., Article 43, Article 44, Article 42, etc.). For entities applying for licensure, provide the anticipated type of licensure.

C. AFFILIATED ENTITIES APPLYING

List any affiliated entities and their respective licensure that will likely also apply for participation, as well as the name of the affiliate applicant.

D. SERVICE AREA

List Applicant's current service area by county. If the service area is all counties within New York State, state "All Counties." Entities in the process of applying for licensure with the State, provide a list of anticipated counties or state "All Counties" if applicable.

E. NUMBER OF PRODUCTS – Health Insurer Applicants

Health Insurer Applicants and CO-OPS, provide the anticipated number of products at each metal level (do not include catastrophic products and child-only products):

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Metal Level	Number	Metal Level	Number
Bronze (60% AV)		Bronze (60% AV)	
Silver (70% AV)		Silver (70% AV)	
Gold (80% AV)		Gold (80% AV)	
Platinum (90% AV)		Platinum (90% AV)	

F. NUMBER OF PRODUCTS – Stand-Alone Dental Carrier Applicants

Stand-Alone Dental Carrier Applicants, provide the anticipated number of products:

INDIVIDUAL EXCHANGE		SHOP EXCHANGE	
Category	Number	Category	Number
Pediatric (High 85%)		Pediatric (High 85%)	
Pediatric (Low 75%)		Pediatric (Low 75%)	
Adult		Adult	
Family		Family	

The above identified entity hereby has interest in participating in the New York Health Benefit Exchange and intends to submit an Application to the Department of Health.

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 New York Health Benefit Exchange sent to the above e-mail address.