NOTICE – RESENDING RETURNED MAIL

You are getting this letter because NY State of Health sent you information, by U.S. mail, to the mailing address provided in your account. However, this mailing was returned to the Marketplace as undeliverable.

We are resending this information to your new address. Enclosed is the original notice that was sent to you and returned to us as undeliverable.

It is important your address is correct in your account.**Make sure that NY State of Health has your current mailing and residential address.** Coverage for you or your family may be impacted if we do not have your current address.

To update your mailing and residential address:

1. Visit www.nystateofhealth.ny.gov and click on “Get Started.” Log in with your username and password and review the addresses in your account.
2. To make a change to an address, click on "Update Application" and enter the newaddress. Be sure to sign and submit your application before you exit. Otherwise, your new information will not be saved.
3. If you forgot your username or password, click on “Forgot your Username or Password”on the sign-in screen. Follow the directions on the screen.
4. Your account is a place where important information about your application for healthinsurance is stored. Keep your username and password in a safe place.

T099

Marley Janson
90 Church St
New York, NY 10007

October 02, 2018
Account ID: AC0000000123

Help at: 1-855-355-5777
TTY: 1-800-662-1220

Important Notice About Your Health Insurance Coverage

It's time for you and/or members of your household to renew your health insurance coverage through NY State of Health, The official Health Plan Marketplace. This letter contains important information about renewing your health insurance coverage.

It is important that you update your NY State of Health application **between September 16, 2018** and **October 15, 2018**. Log in at **www.nystateofhealth.ny.gov** to complete your renewal before your current health insurance coverage ends.

It is renewal time for the following individuals and ACTION IS REQUIRED:

Marley Jansom (AB12345C) **Marketplace ID:**HX0000000123

ACTION REQUIRED:

Based on the information from federal and state sources, we cannot make a decision about whether you qualify for financial help paying for your health insurance coverage.

Please update the information on your NY State of Health account by **October 15, 2018** so we can make an appropriate decision.

NOTE: If you miss this deadline, you are at risk of losing your health insurance coverage and if applicable, any financial assistance.

Call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220) to get help in other languages or for help reading this notice. This notice is also available in other formats. Call for more information. To find a navigator or certified application assistor near you, visit https://www.nystateofhealth.ny.gov or call us.

Be aware that you may be able to buy a health plan at NY State of Health at full cost. See the section of this notice titled *"How and When to Make Changes to Your Account or Plan."*

T099

Find Health Insurance Coverage Information Through NY State of Health

How and When to Make Changes to Your Account or Coverage

Follow the steps below –

IF ... NY State of Health has requested that you complete the renewal process by updating some information (for example, pick a health plan or update information in your application);

IF ... Anything has changed in your life that may affect your health insurance coverage or financial assistance;

IF ... You are enrolled in a plan and want to see if you have other coverage options.

Step 1. Go to www.nystateofhealth.ny.gov and log into your account.

OR

Contact a Navigator or Certified Application Counselor. These individuals, located at a community-based organizations and health plans, are trained to help you understand your health coverage options and enroll in coverage. If you already are enrolled in a plan, you can also call your health plan for assistance.

Step 2. Make changes for you and/or your household members. You need to make the changes between **November 16, 2018** and **December 15, 2018** to see what you qualify for on **January 1, 2019**.

Below are some events in your life or a household member's life that could affect what health insurance coverage you are re-enrolled in, who is covered, or how much you pay. Tell us if:

- You move
- Your income changes (only if you are receiving financial assistance)
- You get access to or enroll in the New York State Health Insurance Program (NYSHIP)
- Your eligibility for health insurance from a job changes
- The cost of your health insurance premium from a job changes
- Your household changes. For example, you marry/divorce, become pregnant, or have a child; adopt a child, or a child is placed for adoption with you
- You become qualified for other health insurance
- There is a change in full-time student status (if applicable to application members)
- There is a change in immigration status

- You change how you plan to file your taxes. For example, you will claim new dependents (only if you are receiving financial assistance)

If you do not report changes within 30 days and they affect your ability to get government help with insurance costs, you may have to pay back some or all of the subsidies you received.

What Happens After You Make Changes to Your Account

You will receive a notice from NY State of Health with information about your new health insurance coverage and any financial assistance you will receive.

How to Contact NY State of Health

Contact us if you have any questions about this Notice. Let us know if you need help applying for or accessing your health insurance coverage.

Call: 1-855-355-5777 (TTY: 1-800-662-1220)
Mail: NY State of Health
PO Box 11727
Albany, NY 12211

Legal Reference:

Listed below are the specific laws and government regulations which give NY State of Health the authority and which set the rules under which we can offer affordable health insurance to New York State residents.

Pursuant to Social Services Law 366-a(5)(a), the NY State of Health must redetermine the eligibility of an enrollee on an annual basis or during the benefit year if it receives and verifies new information.

HIPAA Privacy Notice

New York State is committed to protecting your privacy. To learn more about NY State of Health's privacy practices go to www.nystateofhealth.ny.gov or call customer service at 1-855-355-5777 (TTY: 1-800-662-1220).

Notice of Nondiscrimination Policy

NY State of Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability in its health program and activities.

NY State of Health also complies with applicable state laws and does not discriminate on the basis of race, color, national origin, creed/religion, sex, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

NY State of Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- TTY through NY Relay Service
- Written information in other formats such as large print, audio, accessible electronic formats and other formats

Provides free language assistance services to people whose primary language is not English, such as:

- Qualified interpreters
- Written information in other languages

If you need these services or for more information, contact 1-855-355-5777 (TTY 1-800-662-1220).

If you believe that NY State of Health has discriminated you may file a complaint by going to: http://www.health.ny.gov/regulations/discrimination_complaints/ or, by calling 518-473-1703 or 518-473-7883.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.

Register to Vote

If you are not registered to vote where you live now and would like to register, you can do so:

- Online at the New York State DMV voter registration page http://dmv.ny.gov/more-info/electronic-voter-registration-application.

- By completing the New York State Agency voter registration form included with this notice and mailing it back to us.

Important Information to Know

- Applying to register or declining to register to vote will **not** affect your eligibility or the assistance you will be provided by NY State of Health.

- If you would like help in filling out the voter registration application form or to request a paper voter registration application form, we will help you. For help, contact customer service at 1-855-355-5777 (TTY: 1-800-662-1220). The decision whether to seek or accept help is yours. You may fill out the application form in private.

- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections
40 North Pearl St., Suite
5 Albany, NY 12207-
2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit the website - www.elections.ny.gov

T099

NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ **YES** (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR ☐

I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ____/____/____

(Signature) (Date)

_____

(Please Print Name)

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料:若您有興趣索取中文資料表格,請電: 1-800-367-8683 한국어:

한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

□□□ □□□□ □□ □□□□□□ □□□□□□□ □□□□ □□□ □□□□□

1-800-367-8683 □□□□□□□ □□□□ □□□□

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (01/2011)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1	Are you a U.S. citizen? Yes ☐ No ☐ If you answered NO, do not complete this form.		**2**	Will you be 18 years old on or before election day? Yes ☐ No ☐ If you answered NO, do not complete this form unless you will be 18 by the end of the year.			**For Board use only!**
3	Last Name	First Name		Middle Name	Suffix		
4	Address where you live (do not give P.O. address)	Apt. No.		City/Town/Village	Zip Code	County	
5	Address where you get your mail (if different from above)	P.O. Box, star route, etc.		Post Office	Zip Code		
6	Date of Birth	**7**	Sex (Circle) M F	**8**	Home Tel. Number (optional)		
10	The last year you voted	Your Address was (give house number, street and city)				**9**	ID Number - Check the applicable box and provide your number: ☐ New York DMV number __ __ __ __ __ __ __ __ __ If you do not have a New York DMV number, please provide: ☐ Last four digits of your Social Security Number __ __ __ __ ☐ I do not have a New York Driver's license number
	In county/state	Under the Name (if different from your name now)					

11 **Choose a party** -- Check one box only

☐ Democratic Party

☐ Republican Party

☐ Conservative Party

☐ Working Families Party

☐ Independence Party

☐ Green Party

☐ Other (write in) _____

☐ I do not wish to enroll in a party

12 **AFFIDAVIT:** I swear or affirm that

- I am a citizen of the United States.
- I will have lived in the county, city or village for at least 30 days before the election.
- I will meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years.

→ _____

(Signature or Mark in Ink) (Date)

(Optional) Register to donate your organs and tissues

Last Name_____

First Name_____

Middle Initial_____ Suffix_____

Address_____

Apt Number_____ Zip Code_____

City_____

Birth Date_____ Sex □ M □ F

Eye Color_____ Height___ Ft. ___In.

By signing below, you certify that you are:

•• 18Consent to donate all of your organs and tissues for years of age or older

transplantation, research, or both;

- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.

Sign Date

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

New York State Board of Elections, 40 Steuben Street,
Albany, New York 12207-2109
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the **DMV number (driver's license number or non-driver ID number)**, or the **last four digits of your social security number, which you will fill in Box 9.**

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark(?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. To vote in a primary election, you must be enrolled in one of these listed parties - Except the Independence Party, which permits non-enrolled voters to participate in certain primary elections.

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한한한 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

(Arabic)

".5223ʹ .5777-355-855-1 مDر&5# ل5B?C ا 47ر"ʹ،5واه?6. م/=& دة:5;. &7إ !654# ت23 إذا .!./. ,"+هذه و!#"! ر%&ا

&?JI !HI&5# ك& وري E م4ر?. ر"E و?

.5.254ً ,/5د6??

(Bengali)

□ , ! " 1-855-355-5777

□ $ %& ’ ’ $ %&(□

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

□□□ **(Hindi)**

□□ □□ □□ □□□ □ □□□□□ □□□□ □□□ □□□□ □□□ □□□□□ □! □□□□□□ □□□□, □□ □□□□□ 1-855-355-5777 □□ □□□ □□!□ □□ □□□& □□□□ □□□□□ □□□□ □□ □□□+□□□□ ,□□□/□□ □□□1□ □□□□ □□□□ □3□

日本語 **(Japanese)**

これ 重要な書類です。理解するために支援が必要な場合 、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

□□□□□ **(Nepali)**

□□ □□□□ □□ □□□□ □□□□□□ □□□ □□□□□ □7□ □ □□□8□□□ □9□ □□□:□ □□□, □□□□□ 1-855-355-5777 □□ □□□ □□□□□□□ □□□□□□ □□□8□□ □□/□□ □□□□□□ □□□8□□□ ,□:□□ /□ □□□□□□ □□□1□ □□□□□ □A□B□□

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو **(Urdu)**

و آپ ام U۔ن\ر ل5\ر _ 1-558-553-7775راہ\رام #و ؟ XU رورت^]\دد .X"& X\ X2/4.; ;Xا و آپ ار Yا۔XU ز"و5؟;د ام Uا "Tا S"

۔ن"U X?c; ر\ام Uارم E4ر؟. ت=. "Tا ں ".ن5#دری ز.5]\

Tiếng Việt (Vietnamese) Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

(Yiddish) אידיש

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.