

**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 2025:**

|  |  |  |
| --- | --- | --- |
| **QHP Market(s): Individual ☐** | **SHOP ☐** | **Both Individual/SHOP ☐** |
| **SADP Market(s): Individual ☐****Essential Plan: ☐** | **SHOP ☐** | **Both Individual/SHOP ☐** |

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 2025 on behalf of Applicant.

|  |
| --- |
| 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.

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Attachment E – 2025 Letter of Interest for QHPs, SADPs and Essential Plan

NY State of Health Invitation to Participate