ATTACHMENT D
LETTER OF INTEREST FOR QUALIFIED HEALTH PLAN OR STAND ALONE DENTAL PLAN PARTICIPATION IN THE NY STATE OF HEALTH

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 2016 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.