



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

## **NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL**

Notice Date: February 12, 2016

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000004284

[REDACTED]  
[REDACTED]  
[REDACTED]

On August 9, 2015, the Marketplace issued an eligibility determination notice stating that you qualified to select a health plan outside of the open enrollment period. You appealed this determination because your health plan was not honoring your enrollment and you were unable to have health coverage.

On February 9, 2016, you spoke with a Hearing Officer from the Appeals Unit of NY State of Health. You were placed under oath.

While under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal.

You therefore withdrew your appeal on the record. Accordingly, we are dismissing your appeal, pursuant to 45 Code of Federal Regulations (CFR) § 155.530(a)(1).

### **How does this Dismissal Affect Your Eligibility?**

The Appeals Unit of NY State of Health will not be reviewing this matter.

## **If You Change Your Mind About Withdrawing Your Appeal**

If you change your mind about withdrawing your appeal, you can ask us to vacate (cancel) this dismissal. You must ask us in writing within 30 days after the date on this notice, and explain why you have changed your mind.

The Marketplace's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, the Marketplace will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and the Marketplace will take no further action on your appeal.

## **Appeal Identification Number**

When communicating with the Marketplace about this appeal, please refer to both the Appeal Identification Number and the NY State of Health Number at the top of this notice.

## **How to Contact the Marketplace**

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.530.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

**A Copy of this Notice of Dismissal Has Been Provided To**



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