Assistance with Your Application

You can choose an authorized representative.

You can give a trusted friend, relative, partner, or attorney permission to talk with us about your application and act for you on matters related to your account. This person is called an "authorized representative. "

An authorized representative can:

- Sign your application;
- Help you with redeterminations and renewals;
- Receive copies of notices and other communications;
- Request appeals; and
- Act on your behalf in all other matters with NY State of Health: The Official Health Plan Marketplace.

You should complete this form if:

- You want to name someone as your authorized representative for the first time; or
- You want to change the authorized representative you named at any other time.

If you already have a legal document that authorizes someone to act for you under New York State law, the Marketplace can accept a copy of that document in place of the authorized representative form. Examples of documents that we accept for this purpose are a court order establishing guardianship or a power of attorney form.

Before we can speak with or release information to an authorized representative, we need to verify his or her identity. Your authorized representative can verify his or her identity by completing the **Authorized Representative Identity Verification Form**. If you need to request a copy of this form, please call 1-855-355-5777.

To authorize someone to act as your representative, fill out the form below or provide documents showing that you already have a legally appointed representative. Then return it, along with the Authorized Representative Identity Verification Form and the documents proving identity to the NY State of Health at P.O. Box 11727, Albany, NY 12211. Or fax it to 1-855-900-5557.

Authorized Representative Designation Form

Applicant or Enrollee's name (First name, Last name)		
Mailing address		
City	State	ZIP code
Telephone Number	SSN	Date of Birth (mm/dd/yyyy)

CHECK ONE

The person or organization below is my authorized representative for **all matters** related to my account. ☐

The person or organization below is my authorized representative only to **act as my representative during an appeal.** ☐

By signing, you allow this person or organization to get official information about your account and act for you for the matters you stated above. Your authorization will become effective when we receive this completed form, and it will remain effective until you or your authorized representative tell us that the authorization has ended.

Applicant or Enrollee's signature	Date (mm/dd/yyyy)

Acceptance of Designation

Authorized representative's name (First name, Last name, or Organization name)		
Mailing address		
City	State	ZIP code
Telephone number		☐ Attorney ☐ Non-attorney representative

By signing, you agree to maintain the confidentiality of any information regarding the applicant or enrollee that NY State of Health provides. You also agree to fulfill all the responsibilities encompassed within the scope of this authorization as if you were the applicant or enrollee. You also agree to comply with applicable state and federal laws concerning conflicts of interest.

If you are signing on behalf of an organization, you agree that providers, staff members, and volunteers affirm that they will comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Representative's Signature	Date (mm/dd/yyyy)

NEED HELP WITH THIS FORM? Call us at 1-855-355-5777.
TTY users should call 1-800-662-1220 or 1-877-662-4886 for TTY in Spanish.