

(Date)

(Name of Applicant)

(Street Address)

(City, State, ZIP)

Dear (Name of Applicant):

We regret to inform you that we cannot offer you HIP Healthy New York coverage at this time. The reasons are as follows:

- Your application is incomplete. \* \_\_\_\_\_  
\_\_\_\_\_
- The supporting documentation required to determine your eligibility did not accompany your application\* \_\_\_\_\_  
\_\_\_\_\_
- You are ineligible because you have other health insurance coverage.
- You are ineligible because your employer contributes to the cost of health insurance coverage for which you are eligible.
- You are ineligible because you or your spouse has not been employed during the 52 weeks preceding receipt of your application.
- Your combined family income exceeds the eligible limit.
- Other: \_\_\_\_\_  
\_\_\_\_\_

If you have questions about our decision, you may write to Enrollment Department (Attention: Healthy New York), HIP Health Plan of New York, P.O. Box 2806, New York, NY 10116-2806.

If you wish to appeal the decision, write to: NYS Insurance Department, Consumer Services – Healthy NY, One Commerce Plaza, 20<sup>th</sup> Floor, Albany, NY 11257.

Thank you.

Sincerely,

HIP Health Plan of New York

*\* Please send your missing information or documentation together with this letter within 30 days of the date above to Enrollment Department (Attention: Healthy New York), HIP Health Plan of New York, P.O. Box 2806, New York, NY 10116-2806. We will notify you of our decision in writing.*