

## Application to Revoke Waiver of Yale Health Hospitalization/Specialty Coverage and/or Yale Health Prescription Plus Coverage

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_ I wish to revoke my previous Waiver of Yale Health Hospitalization/Specialty Coverage. I understand that this coverage will become effective as of \_\_\_\_\_ and I will be enrolled in this plan unless I waive coverage during a subsequent waiver period. Please indicate below if you also wish to enroll in Yale Health Prescription Plus:

\_\_\_\_\_ Please enroll me in Yale Health Prescription Plus Coverage

\_\_\_\_\_ I wish to waive enrollment in Yale Health Prescription Plus Coverage

**OR**

\_\_\_\_\_ I wish to revoke my previous Waiver of Yale Health Prescription Plus Coverage. I understand that this coverage will become effective \_\_\_\_\_ and I will be enrolled in this plan unless I waive coverage during a subsequent waiver period.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

### FOR YALE HEALTH USE ONLY

Received Date  
\_\_\_\_\_

IDX Updated  
\_\_\_\_\_

Yale Health Staff Member  
\_\_\_\_\_