

Application to Revoke Waiver

of Yale Health Hospitalization/Specialty Coverage

Date: _____

Student Name: _____ Birth Date: _____

Address: _____

Phone: _____

Student ID Number (SID): _____

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.

Student Signature _____ Date _____

FOR YALE HEALTH USE ONLY

Received Date

IDX Updated

Yale Health Staff Member
