Yale HEALTH

STUDENT ENROLLMENT/CHANGE APPLICATION

Student Dependent or Affiliate Coverage

Return To:
Member Services
P.O. Box 208237
New Haven, CT 06520-8237
Phone: 203.432.0246 Fax: 203.432.4130
e-mail: member.services@yale.edu

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**

Home Address (street, city, state, zip code):

Student ID Number (SID):	**Sex:** □ Male □ Female	**Phone:**	**Email:**

Membership

□ Single □ 2-Person □ Family

Student Status

□ Full-time, Regularly Enrolled
□ Less than Half-time (Affiliate Plan)
□ Leave of Absence (Affiliate Plan)
□ Eli Whitney Program (Affiliate Plan)
□ Extended Study/Reduced Tuition (Affiliate Plan)
□ Study Abroad (Affiliate Plan)
□ Other _____

Period of Enrollment for Yale Health Coverage

□ Full Year – August 1, 2016* through July 31, 2017
□ Fall Term only – August 1, 2016* through January 31, 2017
□ Spring Term only – February 1, 2017 through July 31, 2017
□ Other _____ Effective Date _____

* Fall Term coverage for incoming students begins on the date dormitories open or the date required to be on campus for orientation.

Method of Payment

□ Check □ Cash □ SFAS Account □ Other _____

Enroll eligible spouse/civil union partner and/or dependents under 26 below: Last name , first name, middle Initial	Primary Care Clinician (You may select one for each person)	Birthday Mo.	Day	Year	Sex

This section MUST be completed in order to process your enrollment application.

Will you or any of your dependents have any other health insurance when your Yale Health coverage is effective? □ Yes □ No

If yes, which family members will be covered by other insurance? □ Self □ Spouse/Civil Union Partner □ Children

Name of Carrier _____

Address_____Policy Number _____

Company through which coverage is obtained _____

Agreement

I understand the Yale Health Student Handbook serves as the contract between Yale Health and myself and agree to the terms and conditions therein. I understand coverage for me and/or my dependents will terminate if I am no longer an eligible Yale degree candidate student. I understand there will be a charge(s) associated with adding dependents and I am responsible for payment of these charges. I authorize Yale Health to charge my Bursar charge account or other account. I hereby authorize Yale Health to release any or all medical information for myself or my dependents, to any persons requiring such in processing of medical claims. To the best of my knowledge the information provided in the above application is true and accurate. **It is the student's responsibility to notify the Registrar of any change in status or demographics.**

Signature _____ **Date** _____

FOR YALE HEALTH USE ONLY	**Banner Status**	**GRP/PLN**	**Change (if applicable)**
Yale Health Effective Date _____			□ Single to 2-Person □ Single to Family
Database Update _____			□ 2-Person to Family □ Other _____