

Yale HEALTH

STUDENT ENROLLMENT/CHANGE APPLICATION 2023-2024 Student Dependent or Affiliate Coverage

All fields in red are required.

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

Student ID Number (SID):	Sex/Gender Identity:	Phone:	Email:
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Membership

Single Student plus spouse Student plus child(ren) Family—student plus spouse plus child(ren)

Student Status

Full-time, Regularly Enrolled Leave of Absence (Affiliate Plan)
 Less than Half-time (Affiliate Plan) Study Abroad (Affiliate Plan)
 Other _____

Period of Enrollment for Yale Health Coverage

*If you want to continue your coverage past your end date you must re-enroll before **September 15** for full year or fall term, and before **January 31** for spring term.*

Selection	Length of Enrollment	Start Date	End Date	Rates Per Term**	
	Full Year	August 1, 2023*	July 31, 2024	Single	\$1,447
	Fall Term <u>only</u>	August 1, 2023*	January 31, 2024	Student plus spouse	\$5,382
	Spring Term <u>only</u>	February 1, 2024	July 31, 2024	Student plus child/ren	\$4,843
				Family	\$9,030

**Rates displayed are not for the affiliate plan.

* 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

Credit or Debit Card Yale College Financial Award GSAS Premium Award Other

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

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 my dependents, to any persons requiring such in processing of medical claims or myself. 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)
Effective Date _____			From: _____
Database Update _____			To: _____

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