Yale HEALTH

School of Management EMBA Program 2024-25 Student Enrollment Application for Yale Health Hospitalization/Specialty Care Coverage (Affiliate/Self-Pay)

Return To:
Yale School of Management
Attn: EMBA Program
165 Whitney Avenue
New Haven, CT 06511
emba@yale.edu

DEADLINES:
Full year or fall term: July 15, 2024
Spring term only: January 15, 2025

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

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

Student ID Number (SID):	**Daytime Phone:**	**Evening Phone:**

Membership

□ Single
□ Student plus spouse
□ Student plus child(ren)
□ Family–student plus spouse plus child(ren)

Rates

Single: $4,476 per term, $8,952 full year
Student plus spouse: $8,334 per term, $16,668 full year
Student plus child(ren): $7,501 per term, $15,002 full year
Family: $11,705 per term, $23,410 full year

Period of Enrollment for Yale Health Hospitalization/Specialty Care Coverage

□ Full Year – August 1, 2024 - July 31, 2025
□ Fall Term only – August 1, 2024 - January 31, 2025
□ Spring Term only – February 1, 2025 - July 31, 2025
□ Other _____ Effective Date
_____

Enroll eligible spouse/civil union partner and/or dependents under 26 below: Last Name	First Name	Middle Initial	Chosen name	Primary Care Clinician (You may select one for each person)	Birthday MM	DD	YYYY	Sex at Birth	Gender Identity

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 that the coverage outlined in 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 SFAS 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 _____ Database Update _____			From _____ To _____