

Yale HEALTH

Request to REVOKE the Waiver of Yale Health Hospitalization/Specialty Care Coverage

All fields in red are required.

Return To:

Member Services
55 Lock Street
P.O. Box 208237
New Haven, CT 06520-8237

Phone: 203.432.0246 Fax: 203.432.4130
e-mail: member.services@yale.edu

Students who decide to revoke the waiver of Yale Health Hospitalization/Specialty Care Coverage are responsible for providing Yale Health with proof that you have experienced a qualifying life event, **within 30 days**, that would allow you to re-enroll in Yale Health Hospitalization/Specialty Care Coverage. **Fees for Yale Health Hospitalization/Specialty Care Coverage will not be prorated or refunded, and you will be responsible for the full premium.**

Last Name:	First Name:	Chosen Name:	Middle Initial:	Date of Birth:
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Home Address (street, city, state, zip code):

Student ID Number (SID):	Daytime Phone:	Evening Phone:
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Attach Proof of your Qualifying Life Event – This section MUST be completed in order to process your revoke waiver request.

Examples of Qualifying Life Events:

- Loss of alternate health insurance coverage

Period of Revoke Waiver Request:

The deadline to revoke a waiver for the Fall term or full year is **September 15th**, unless you have a qualifying life event.
The deadline to revoke a waiver for the Spring term is **January 31st**, unless you have a qualifying life event.

Full Year: August 1, 2024 to July 31, 2025. *

Fall term **only**: August 1, 2024 to January 31, 2025. *

Spring term **only**: February 1, 2025 to July 31, 2025. *

**I understand that my coverage start date may be different than what is listed above. The start date of coverage is solely dependent on the qualifying life event.*

Agreement

I certify that, upon receiving confirmation of my revoke waiver's approval, I will be a current member of the health insurance program identified above and will continue my enrollment for the period of time indicated above or explicitly confirmed by Yale Health staff. I understand that I am responsible for the fees associated with Yale Health Hospitalization/Specialty Care Coverage. Fees will not be prorated or refunded, and you will be responsible for the full premium.

I request that payment of authorized health care benefits be made on my behalf directly to Yale Health for services provided by Yale Health and I authorize that any medical information needed to determine these benefits be released to my health insurance carrier. I understand that the insurance carrier may release information to the policy holder.

I have read the above, understand it, and wish to revoke my previous waiver of and re-enroll in Yale Health Hospitalization/Specialty Care coverage. I further certify that the information provided above is true and complete.

Signature _____

Date _____

Please refer to the Yale Health Student Handbook, yalehealth.yale.edu/coverage/student-coverage for a complete description of the Yale Health Hospitalization/Specialty Care coverage. Confirmation of receipt of the Revoke Waiver Request Form is the student's responsibility.

[**Click to Submit to Member Services**](#)