Yale HEALTH

STUDENT ENROLLMENT/CHANGE APPLICATION

2024-2025 *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:**	**Chosen Name:**	**Middle Initial:**	**Date of Birth:**

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

Student ID Number (SID):	**Sex at Birth:**	**Gender Identity:**	**Phone:**	**Email:**

Membership

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

Student Status

◯ Full-time, Regularly Enrolled
◯ Less than Half-time (Affiliate Plan)
◯ Leave of Absence (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**
◯	Full Year	August 1, 2024*	July 31, 2025
◯	Fall Term only	August 1, 2024*	January 31, 2025
◯	Spring Term only	February 1, 2024	July 31, 2025

Rates Per Term**

Single	**$1,556**
Student plus spouse	**$5,786**
Student plus child/ren	**$5,206**
Family	**$9,707**

**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 (chosen name)	Primary Care Provider (You may select one for each dependent)	Birth date Mo. Day Year	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 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 _____ Database Update _____			From: _____ To: _____

Click to Submit to Member Services