Yale HEALTH

UNDERGRADUATE AFFILIATE COVERAGE
ENROLLMENT FORM 2024 - 2025
For Yale College students on a medical leave of absence only

Return To:
Yale Health Member Services
Phone: 203.432.0246
email: yh_undergraduateaffiliatecoverage@yale.edu

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

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

Student ID Number (SID):	**Sex:**	**Phone:**	**Email:**

Membership and Cost Per semester

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

Student Status □ Leave of Absence (Undergraduate Affiliate Coverage)

Rates
- ☐ Single: $4,726 per term
- ☐ Student/spouse: $8,834 per term
- ☐ Student/child(ren): $7,951 per term
- ☐ Family (student/spouse/child(ren): $12,455

Period of Enrollment for Undergraduate Affiliate Coverage*

Selection	Length of Enrollment	Start Date	End Date
☐	Fall Term only	August 1, 2024*	January 31, 2025
☐	Spring Term only	February 1, 2025*	July 31, 2025

*Students must request and complete enrollment into Undergraduate Affiliate Coverage within **30 days** of the date the leave is granted.

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	Birth date 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
Students who elect to purchase Undergraduate Affiliate Coverage must also remain enrolled in Yale Health Hospitalization/Specialty Care coverag and are responsible for premium charges for the coverage as well as all copays, deductibles, coinsurance fees, and bills resulting from non-covered or partially covered services by Yale Health and Aetna.The premium due for the level of coverage (single, student plus spouse, student plus child/ren, family) you select will be billed to your Student Financial & Administrative Services (SFAS) account. Applicable copays, deductibles, coinsurance fees, and bills resulting from non-covered or partially covered services will be collected directly from you by the provider of service either at the time of service or afterwards. I have read the plan summary information, understand it, and wish to enroll in the Undergraduate Affiliate Coverage. I fully certify that the information provided is true and complete.

Signature______________________________ Date ______________________________

FOR YALE HEALTH USE ONLY	**Banner Status**	**GRP/PLN**	**Change (if applicable)**
Effective Date _			From: ______________
Database Update ______________			To: ______________

Rev. 05/2024