Yale HEALTH

Request to WAIVE 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 waive the Yale Health Hospitalization/Specialty Care coverage are responsible for all bills and fees resulting from specialty services at the Yale Health Center and services rendered outside of the Yale Health Center, even if referred by a Yale Health provider.

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:**

Your Alternate Insurance – This section MUST be completed in order to process your enrollment application, or you may submit a copy of the front and back of your alternate insurance card.

Name of Carrier _____

Address_____ Policy Number _____

Policy Holder _____ Relationship to Insured _____

Employer, if employer provides insurance _____

Period of Waiver Request:

The deadline to waive for the Fall term or full year is September 15th.
The deadline to waive for the Spring term is January 31st.

- ○ 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 I will be enrolled in and billed for the Yale Health Hospitalization/Specialty Care coverage as of that date unless a new waiver form is submitted.* ***Fall Term coverage for incoming students begins on the date dormitories open or the date required to be on campus for orientation.***

Agreement

I certify that I am currently a member of the health insurance program identified above and will continue my enrollment for the period of time indicated above. I understand that I am responsible for all medical expenses including Yale Health specialty care services that are not covered by my health insurance even if referred by a Yale Health clinician.

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 waive enrollment in the Yale Health Student 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 Waiver Request Form is the ***student's responsibility.***

Click to Submit to Member Services