Yale HEALTH

Unpaid Post Doc - Associate Enrollment Form

Submit Form

Please send completed forms to member.services@yale.edu and Robin.soltesz@yale.edu.

Last Name	First Name	Middle Initial
Home Address (street, city, state, zip code)		Phone:

Birthdate _____/_____/_____ Month / Day / Year	Sex at Birth: _____	Gender Identity: _____

Yale University Net ID:	Employment Category: ◯ Postdoc Fellow ◯ Postdoc Associate ◯ Visiting Scholar ◯ Faculty ◯ VAR ◯ Non-Degree Student ◯ Daycare Employee ◯ Other Describe:_____

Department:	Title:	Date of Employment/Affiliation:	Department/Program Contact:

Are you receiving a Yale University paycheck? ◯ Yes ◯ No If no, please complete page 2.	Marital Status: ☐ Single ☐ Married/Civil Union Have you or your dependents been Yale Health members previously? Yes No	Length of appointment: __/__/__ - __/__/__ Category of Membership ☐ Single ☐ Subscriber plus child/ren ☐ Subscriber plus spouse ☐ Family

PLEASE LIST DEPENDENTS TO BE ENROLLED IN YALE HEALTH BELOW:

	Last Name	First Name	Initial	Birthdate MM/DD/YYYY	Sex at Birth & Gender Identity
SPOUSE/CIVIL UNION PARTNER					
CHILD					
CHILD					
CHILD					
CHILD					

This section MUST be completed to process your enrollment and allow your Yale Health membership to become effective.

Will you or any of your dependents have other health insurance when your Yale Health coverage is effective? ☐ Yes ☐ No

If yes, which family members will be covered by the other insurance? ☐ Self ☐ Spouse/Civil Union Partner ☐ Children

Name of carrier: _____ Address: _____

Policy number: _____ Company through which coverage was obtained: _____

Agreement

I understand that the Member Coverage Booklet serves as the contract between Yale Health and myself and agree to the terms and conditions therein, including the right of Yale Health to amend any provisions upon written notification to members. I also understand and agree that covered benefits for professional and specialty services not available at the Yale Health Center are covered only when an authorized referral is made by a Yale Health provider. I authorize the University and/or Yale Health to make periodic deductions from my payroll check (if applicable) or authorize monthly billing for membership in Yale Health. I agree that failure to remit payment will result in termination of Yale Health membership. 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. The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

For Yale Health Use Only	Database	GRP/PLN	CC to COB/Claims
Yale Health Effective Date _____ ☐ AE ☐ Switch of Main Subscriber ☐ FSB ☐ Other: _____	Date: _____ Initial: _____		

Yale HEALTH

2025 YHP Health Care Premium Form for Unpaid Post-Doctoral Fellows

Start Date	End Date

Last Name	First Name
Department	

Enrollment Option (please check one):

Single	$	1,001.00 per month
Employee + Child(ren)	$	1,902.00 per month
Employee + Spouse	$	2,102.00 per month
Family	$	3,003.00 per month

*Rates change annually on January 1st

TO BE COMPLETED BY DEPARTMENT/SCHOOL BUSINESS OFFICE

Funding Sources:		**Monthly Amount**	**COA**
PDF (Self-Pay)	$	-	
Department	$	-	
University	$	-	

Department Name: _____

Department Contact: _____

Contact Phone Number _____

Department Signature: _____

Post Doc Office Authorized Signature: _____