

## Yale University Enrollment/Change Form

### Clerical, Technical, Service, Maintenance Employees

C+T Employee     S+M Employee    Department: \_\_\_\_\_    Date of Hire: \_\_\_\_\_

New Enrollment in Medical and/or Dental     Cancellation or Medical and/or Dental\*     Change in Medical and/or Dental\*  
\*A change or cancellation requested outside of an Annual Enrollment period must be accompanied by a completed Benefits Revision Form.

*Please print clearly and be sure to sign and date below*

|                   |                                                                                                       |
|-------------------|-------------------------------------------------------------------------------------------------------|
| Last Name         | First Name                                                                                            |
| Home Address      |                                                                                                       |
| City              | State                                                                                                 |
| Zip code          |                                                                                                       |
| Home Number:      | Work Number:                                                                                          |
| Mobile Number:    |                                                                                                       |
| Social Security # | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____ |

**Medical and Dental Selections: Please complete the following section for yourself and each covered dependent.**

|                          | First Name | Last Name | Gender<br>M/F | Date of<br>Birth | Medical Selection                  |                      |       | Dental Selection |       | Cancellation |        |
|--------------------------|------------|-----------|---------------|------------------|------------------------------------|----------------------|-------|------------------|-------|--------------|--------|
|                          |            |           |               |                  | Insert a check for each Individual |                      |       |                  |       |              |        |
| Employee                 |            |           |               |                  | YHP                                | Aetna<br>Copay<br>Rx | Waive | Delta            | Waive | Medical      | Dental |
| Legal Spouse             |            |           |               |                  |                                    |                      |       |                  |       |              |        |
| Civil Union<br>Partner * |            |           |               |                  |                                    |                      |       |                  |       |              |        |
| Child 1                  |            |           |               |                  |                                    |                      |       |                  |       |              |        |
| Child 2                  |            |           |               |                  |                                    |                      |       |                  |       |              |        |
| Child 3                  |            |           |               |                  |                                    |                      |       |                  |       |              |        |
| Child 4                  |            |           |               |                  |                                    |                      |       |                  |       |              |        |

DEPENDENT ELIGIBILITY FOR MEDICAL BENEFITS - children over age 19 must be an unmarried financial dependent (or receiving over 50% financial support), enrolled as a full time student, or disabled. DEPENDENT ELIGIBILITY FOR DENTAL BENEFITS – children over age 19 must be an unmarried dependent attending school full-time or disabled. Dependent eligibility verification will be requested annually. Failure to reply will terminate that benefit. Provide name of school 19+ dependent is attending: \_\_\_\_\_

\*Indicate from which State you have a Civil Union License \_\_\_\_\_ This is required to determine state income tax exemptions (if applicable).

|                                                                                                                                                                                   |                     |                    |                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------|------------------------------------|
| <b>Other Medical/Dental Coverage Disclosure</b>                                                                                                                                   |                     |                    |                                    |
| ▪ Will you or any of your dependants continue to have coverage by any other medical and/or dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes / continue below |                     |                    |                                    |
| Name of Other Medical Insurance company                                                                                                                                           |                     | Name of subscriber |                                    |
| Name of Other Dental Insurance company                                                                                                                                            |                     | Name of subscriber |                                    |
| ▪ Do you or any covered member have Medicare/Medicaid coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes / continue below                                         |                     |                    |                                    |
| Name                                                                                                                                                                              | Medicare/Medicaid # | Effective Date     | Part A                      Part B |
| Name                                                                                                                                                                              | Medicare/Medicaid # | Effective Date     | Part A                      Part B |

I authorize my employer to deduct any premium contribution from my pay for the coverage selected. I certify that all the above information is correct to the best of my knowledge and that all dependents listed above are eligible for coverage under the terms of the plan I have selected. I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or eligible dependents as well as discipline up to and including termination of employment. I further understand that my file may be audited at any time to determine the eligibility of myself and/or any dependent listed on this application. I certify that I understand benefits, coverage and services as summarized in the plan materials and that these benefits, coverage and services are subject to the exclusions, limitations and conditions as set forth in plan documents. I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family members to furnish such records as may be requested by the above selected insurer, for purposes related to coverage, providing confidentiality is maintained. A copy of this authorization shall be as effective as the original. This authorization is valid for as long as I am enrolled in the above selected plan.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

This section to be completed by the Benefits Office:

COVERAGE EFFECTIVE DATE \_\_\_\_\_ Processed by: \_\_\_\_\_ Oracle: \_\_\_\_\_ Vendor site: \_\_\_\_\_ Date: \_\_\_\_\_

Dependent Start Date for Dental \_\_\_\_\_