

YALE UNIVERSITY POST DOCTORAL FELLOW

New Enrollment Change

SECTION 1: To be completed by Post Doc Fellow

Please PRINT CLEARLY and be sure to SIGN and DATE below.

Submit completed form to the Employee Service Center

LAST NAME		FIRST NAME	
Home Address		City	State Zip
Home Number:		Work Number:	Mobile Number:
Social Security or Yale ID#		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
DEPARTMENT		DATE OF HIRE	

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

	First Name	Last Name	Gender M/F	Date of Birth	Insert a check for each member listed Medical Selection				Insert a check for each member listed Dental Selection		To Cancel Coverage check all that apply	
					YHP	AETNA POS II	AETNA HDHP	Waive	Delta	Waive	Medical	Dental
					Employee							
Legal Spouse												
Civil Union 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).

Other Medical/Dental Coverage Disclosure:

Will you or any of your dependents continue to have coverage by any other medical and/or dental plan? No Yes / continue below

Name of Other Medical Insurance company

Name of subscriber

Name of Other Dental Insurance company

Name of subscriber

I authorize Yale University 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 from Yale University. 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

SECTION 2: To be completed by Department

Departmental Authorization to Subsidize MEDICAL Coverage for Post-Doctoral Fellows (select one):

Standard Formula (RATE EQUIVALENT TO YALE HEALTH PLAN COVERAGE) FOR:

SINGLE TWO PERSON FAMILY **OR** Alternate Flat Monthly Amount of \$ _____

2009 RATES FOR YALE HEALTH PLAN ARE \$410.00 (SINGLE) / \$902.00 (TWO PERSON) / \$1230.00 (FAMILY), AND SUBJECT TO INCREASES AT THE START OF EACH CALENDAR YEAR. The election indicated above is to be charged to the grant. Any premium difference for the medical coverage elected by the Fellow will be charged directly to the Fellow's stipend check.

DEPARTMENT: _____ **SUBSIDY START DATE:** _____ **END DATE:** _____

Authorized by: (print full name) _____ **Tel #** _____

Signature: _____ **Date:** _____

Yale University Employee Service Center: Tel (203) 432-5552 Fax (203) 432-5153 Address: P.O.Box 208256, 221 Whitney Ave. New Haven, CT 06520

This section to be completed by the Benefits Office:

COVERAGE EFFECTIVE DATE _____

Processed by: _____

Oracle: _____

Vendor site: _____