

Yale University

Disabled Dependent - Eligibility Verification Statement

Employee Information

Name: _____

Social Security #: _____

Indicate Which Plan(s) Dependent Is To Be Enrolled In:

MEDICAL PLANS

- Aetna POS II
- Yale Health Plan

DENTAL PLANS

- Delta Dental Assistance Plan for CT/SM
- CIGNA Dental Care (HMO Plan) for CT/SM
- Delta Faculty / MP Dental Plan

Dependent Information

Name: _____

Social Security #: _____

Male Female Date of Birth _____

I certify that the above dependent is my natural or legally adopted child. To qualify, I understand that a "disabled dependent" must be unmarried and found to be incapable of sustaining employment by reason of physical or mental handicap. The dependent became disabled prior to reaching the age of 19, and remains dependent on me for financial support. I understand that a "disabled dependent" may continue to be eligible for Medical/Dental benefits indefinitely as long as they qualify. Note: You will need to supply requested satisfactory proof (no more than once a year) to the Medical and/or Dental Provider confirming the child remains unable to work and is dependent on you for support.

I certify that this information is true to the best of my knowledge. I agree to notify the Employee Service Center in writing within 30 days of any loss of dependency. I understand that the Benefits Office has the right to cancel coverage of any ineligible dependents and that the result of this rescission of coverage will be non-payment of claims for the ineligible dependent.

Employee Signature _____

Important: Please return this signed statement to the Yale University Employee Service Center with a copy of the completed verification enclosures.

Yale University Employee Service Center
221 Whitney Ave.
PO Box 208256
New Haven, CT 06520-8256
Fax # (203) 432-5153