Yale Health Plan
P.O. Box 208237
New Haven, CT 06520-8237
(203) 432-0246 Fax #: 432-4130

EMPLOYEE/YALE ASSOCIATE COBRA EXTENSION PLAN APPLICATION
18 Month Option

Subscriber's Name :___________________________ SS#:___________________________

Spouse's Name (if applicable):___________________________ Tel. No: ___________________________

Billing Address:____

Category of Membership	**Monthly Premium** (effective 1/1/07)
☐ Single	$316.20
☐ 2- person	$820.08
☐ Family	$1,112.82

Please list members who wish to be covered under this COBRA Extension Plan below:

Name Last	First	Initial	**Primary Care Clinician** (Select One for Each Person)	**Social Security #**	**Birthday** Mo.	Day	Year	**Sex**
Subscriber								
Spouse/Same Sex Domestic Partner								
Child								
Child								
Child								

I(we) hereby apply for continuation of Yale Health Plan membership:

From ______________________ **To** ___________________________

I (we) understand Yale Health Plan will extend coverage for the full 18 month period unless I (we) indicate otherwise. I(we) authorize the Yale Health Plan to bill me/us on a monthly basis for the category of membership indicated above. I(we) understand this request for continuation of coverage must be submitted within 60 days of the termination date of employee membership. Membership in the Cobra Extension Plan will begin on the first of the month following the employee coverage termination date.

I(we) understand that I(we) will no longer be eligible to continue coverage through Yale Health Plan under the following circumstances:

- I(we) become eligible for health coverage through an employer group plan.
- I(we) become eligible for Medicare.
- I(we) remarry and become eligible for coverage under my spouse's health plan.

I(we) agree to inform the Yale Health Plan, in writing, of the desire to terminate coverage before the last day of the month for which I(we) have prepaid coverage or if the above circumstances occur. I(we) will be responsible for all premiums due prior to my/our request for termination and I(we) understand that membership is subject to cancellation within 30 days from notice of non-payment of premiums.

______________________________ ______________________
Subscriber Signature Date

______________________________ ______________________
Spouses Signature (if applicable) Date

YHP USE ONLY	Database	Deductions	BC	Term Date	Notice
Effective date:					

revised 11/06