

YALE HEALTH PLAN (YHP)

17 Hillhouse Avenue
P.O. Box 208237
New Haven, CT 06520-8237
(203) 432-0246
Fax: (203) 432-4130

**APPLICATION TO REVOKE WAIVER OF
YHP HOSPITALIZATION/SPECIALTY CARE PLAN
COVERAGE AND/OR YHP PRESCRIPTION
SUPPLEMENTAL BENEFIT PLAN**

Date: _____

Student Name: _____

SS#: _____

Address: _____

Birthdate: _____

_____ I wish to revoke my previous Waiver of Yale Health Plan Hospitalization/Specialty Care Plan coverage. I understand that this coverage will become effective _____ and I will be enrolled in this plan unless I waive coverage during a subsequent waiver period. Please indicate below if you also wish to enroll in the YHP Prescription/Supplemental Benefit Plan:

_____ Please enroll me in the YHP Prescription/Supplemental Benefit Plan.

_____ I wish to waive enrollment in the YHP Prescription/Supplemental Benefit Plan.

OR

_____ I wish to revoke my previous Waiver of YHP Prescription/Supplemental Benefit Plan coverage. I understand that this coverage will become effective _____ and I will be enrolled in this plan unless I waive coverage during a subsequent waiver period.

Student Signature

Date

FOR YHP USE ONLY		
Received Date _____	HSTA Updated _____	YHP Staff Member _____