

 Yale Health Plan	STUDENT ENROLLMENT/CHANGE APPLICATION <i>Student Dependent or Affiliate Coverage</i>	Return To: Member Services 17 Hillhouse Ave. P.O. Box 208237 New Haven, CT 06520-8237 Phone: 203.432.0246 Fax: 203.432.4130 e-mail: member.services@yale.edu	
Last Name:	First Name:	Middle Initial:	Date of Birth:
Home Address (street, city, state, zip code):			
Social Security Number:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Phone:	Evening Phone:
Membership <input type="checkbox"/> Single <input type="checkbox"/> 2-Person <input type="checkbox"/> Family		Coverage <input type="checkbox"/> Hospitalization/Specialty <input type="checkbox"/> Hospitalization/Specialty & Prescription/Plus	
Student Status <input type="checkbox"/> Full-time, Regularly Enrolled <input type="checkbox"/> Less than Half-time (Affiliate Plan) <input type="checkbox"/> Leave of Absence (Affiliate Plan) <input type="checkbox"/> Eli Whitney Program (Affiliate Plan) <input type="checkbox"/> Extended Study/Reduced Tuition (Affiliate Plan) <input type="checkbox"/> Study Abroad (Affiliate Plan) <input type="checkbox"/> Other _____		Period of Enrollment for Yale Health Plan Coverage <input type="checkbox"/> Full Year – September 1, 2008 through July 31, 2009** <input type="checkbox"/> Fall Term <u>only</u> – September 1, 2008 through January 31, 2009 <input type="checkbox"/> Spring Term <u>only</u> – February 1, 2009 through July 31, 2009** <input type="checkbox"/> Other _____ Effective Date _____ <small>*Fall Term coverage for 2009 will begin on August 1st and end on January 31st and reflect six months. **Full year coverage for academic year 2009-2010 and beyond will reflect 12 months.</small>	
Method of Payment <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> SFAS Account <input type="checkbox"/> Other _____			
Enroll eligible spouse/same gender partner and/or dependents under 19 below:		Primary Care Clinician <small>(You may select one for each person)</small>	Social Security Number
Last Name	First Name	Middle Initial	Sex
This section MUST be completed in order to process your enrollment application.			
Will you or any of your dependents have any other health insurance when your YHP coverage is effective? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, which family members will be covered by other insurance? <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Same Gender Partner <input type="checkbox"/> Children			
Name of Carrier _____			
Address _____ Policy Number _____			
Company through which coverage is obtained _____			
Agreement			
I understand that the Yale Health Plan Student Handbook serves as the contract between YHP and myself and agree to the terms and conditions therein. I understand coverage for me and/or my dependents will terminate if I am no longer an eligible Yale degree candidate student. I understand there will be a charge(s) associated with adding dependents and I am responsible for payment of these charges. I authorize the Yale Health Plan to charge my Bursar charge account or other account. I hereby authorize YHP to release any or all medical information for myself or my dependents, to any persons requiring such in processing of medical claims. To the best of my knowledge the information provided in the above application is true and accurate. It is the student's responsibility to notify the Registrar of any change in status or demographics.			
Signature _____			Date _____
FOR YHP USE ONLY	Banner Status	GRP/PLN	Change (if applicable)
YHP Effective Date _____			<input type="checkbox"/> Single to 2-Person <input type="checkbox"/> Single to Family
Database Update _____			<input type="checkbox"/> 2-Person to Family <input type="checkbox"/> Other _____