

Yale Health Plan

STUDENT ENROLLMENT/CHANGE APPLICATION Student Dependent or Affiliate Coverage

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:
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Home Address (street, city, state, zip code):

Social Security Number:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Phone:	Evening Phone:
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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
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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 – August 1, 2009* through July 31, 2010 <input type="checkbox"/> Fall Term <u>only</u> – August 1, 2009* through January 31, 2010 <input type="checkbox"/> Spring Term <u>only</u> – February 1, 2010 through July 31, 2010 <input type="checkbox"/> Other _____ Effective Date _____ * Fall Term coverage for incoming students begins on the date dormitories open or the date required to be on campus for orientation.
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Method of Payment
 Check Cash SFAS Account Other _____

Enroll eligible spouse/same gender partner and/or dependents under 19 below:			Primary Care Clinician (You may select one for each person)	Social Security Number	Birthday			Sex
Last Name	First Name	Middle Initial			Mo.	Day	Year	

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? Yes No

If yes, which family members will be covered by other insurance? Self Spouse/Same Gender Partner 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 YHP Effective Date _____ Database Update _____	Banner Status	GRP/PLN	Change (if applicable) <input type="checkbox"/> Single to 2-Person <input type="checkbox"/> Single to Family <input type="checkbox"/> 2-Person to Family <input type="checkbox"/> Other _____
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