

Yale Health Plan

17 Hillhouse Avenue
P.O. Box 208237
New Haven, CT 06520-8237
Suite 414 - 432-0275
- 432-7877

**INSURANCE INFORMATION
UPDATE FORM**

Please include a copy of your non-YHP insurance card.

Policy Holders Name: _____ Date of Birth: _____
(please print)

Address: _____

Telephone Number: _____

If you or your spouse have other health information, please complete the following:

Policy Holders Name _____

Policy Holders Employer _____

Relationship to Subscriber Self Spouse Children

Other Insurance Carrier _____
(including Medicare)

Billing Address _____

P.O. Box _____

City, State, Zip _____

Identification Number _____ Prescription Drug Rider Yes No

Group number _____ **Effective date** _____

Family members covered by other insurance:

Name	I. D. / Group Number	Date of Birth

Authorization

I hereby authorize Yale Health Plan to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to Yale Health Plan. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signature

Date