

Yale University Enrollment / Change Form

C+T Employee *S+M Employee*

New Enrollment in Medical and/or Dental Cancellation of Medical and/or Dental
 Change in Medical and/or Dental Reason: _____

Please print clearly and be sure to sign and date below

Last Name	First Name	
Home Address		
City	State	Zip code
Home Number:	Work Number:	Mobile Number:
Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
Department	Date of Hire	

Medical and Dental Selections: Please complete the following section for yourself and each covered dependent.

	First Name	Last Name	Gender M/F	Date of Birth	Medical Selection			Dental Selection		Cancellation of Coverage	
					Insert a check for each Individual						
					YHP	Aetna	Waive	Delta	Waive	Medical	Dental
Employee						C o p y	D e d u c				
Legal Spouse											
Civil Union Partner **											
Partner's Social Security Number:											
Child 1*											
Child 2*											
Child 3*											
Child 4*											

**Dependent eligibility for Medical Benefits - children over age 19 must be an unmarried financial dependent (or receiving over 50% financial support), enrolled as a full time student, or disabled. Dependent eligibility for Dental Benefits – children over age 19 must be an unmarried dependent attending school full-time or disabled. Dependent eligibility verification will be requested annually. Failure to reply will terminate that benefit. Provide name of school 19+ dependent is attending: _____*

***Indicate from which State you have a Civil Union License _____ This is required to determine state income tax exemptions (if applicable).*

Other Medical/Dental/Medicare Coverage Disclosure	
▪ Will you or any of your dependents continue to have coverage by any other medical and/or dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes / continue below	
Name of Other Medical Insurance company	Name of subscriber
Coverage effective date	Coverage end date
Name of Other Dental Insurance company	Name of subscriber
Coverage effective date	Coverage end date

I authorize my employer to deduct any premium contribution from my pay for the coverage selected. I certify that all the above information is correct to the best of my knowledge and that all dependents listed above are eligible for coverage under the terms of the plan I have selected. **I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or eligible dependents as well as discipline up to and including termination of employment. I further understand that my file may be audited at any time to determine the eligibility of myself and/or any dependent listed on this application.** I certify that I understand benefits, coverage and services as summarized in the plan materials and that these benefits, coverage and services are subject to the exclusions, limitations and conditions as set forth in plan documents. I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric, substance abuse, and confidential HIV related information) of me and my family members to furnish such records as may be requested by the above selected insurer, for purposes related to coverage, providing confidentiality is maintained. A copy of this authorization shall be as effective as the original. This authorization is valid for as long as I am enrolled in the above selected plan.

Employee Signature _____

Date _____

Submit completed form to: Benefits Office, 155 Whitney Ave Rm 130, P.O.Box 208256, New Haven Ct 06520 or FAX to: 203 432-7575

This section to be completed by the Benefits Office:

COVERAGE EFFECTIVE DATE _____ **Processed by:** _____ **Date:** _____ **Oracle:** _____ **Vendor site:** _____