

# Yale University Enrollment / Change Form

**M+P Employee**     
  **Faculty**     
  **Post Doctoral Associate**

New Enrollment in Medical, Dental and/or Vision     
  Cancellation of Medical, Dental and/or Vision

Change in Medical, Dental and/or Vision Reason: \_\_\_\_\_

**Please note: all changes must accompany a benefit revision request form and proper documentation.**

**Please print clearly and be sure to sign and date below**

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

**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		Vision Selection	
					Insert a check for each individual							
					YHP	Aetna POS II	Aetna HDHP	Waive/Cancel	Delta	Waive/Cancel	EyeMed	Waive/Cancel
<b>Employee</b>												
<b>Legal Spouse</b>												
<b>Civil Union Partner **</b>												
Partner's Social Security Number:												
<b>Child 1*</b>												
<b>Child 2*</b>												
<b>Child 3*</b>												
<b>Child 4*</b>												
<b>Child 5*</b>												

*\*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/Vision/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
Name of Other Vision 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:** \_\_\_\_\_