

Yale University Enrollment/Change Form

Managerial & Professional, Faculty and Post-Doctoral Associates

M+P Employee Faculty Post Doctoral Associate Department: _____ Date of Hire: _____

New Enrollment in Medical and/or Dental Cancellation or Medical and/or Dental* Change in Medical and/or Dental*
**A change or cancellation requested outside of an Annual Enrollment period must be accompanied by a completed Benefits Revision Form.*

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 _____

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				Dental		Vision		Cancellation of Coverage		
					Insert a check for each Individual										
					YHP	Aetna POS II	Aetna HDHP	Waive	Delta	Waive	EyeMed	Waive	Medical	Dental	Vision
Employee															
Legal Spouse															
Civil Union Partner*															
Child 1															
Child 2															
Child 3															
Child 4															
Child 5															

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 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			
Name of Other Dental Insurance company	Name of subscriber			
▪ Do you or any covered member have Medicare/Medicaid coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes / continue below				
Name	Medicare/Medicaid #	Effective Date	Part A	Part B
Name	Medicare/Medicaid #	Effective Date	Part A	Part B

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
<i>This section to be completed by the Benefits Office:</i>	
COVERAGE EFFECTIVE DATE _____	Vendor: _____ Aetna Suffix: _____ Delta Sub Loc: _____
	Processed by: _____ Oracle: _____ Date: _____