

<h1 style="margin: 0;">Yale HEALTH</h1> <h2 style="margin: 0;">UNDERGRADUATE AFFILIATE COVERAGE ENROLLMENT FORM 2023 - 2024</h2> <p style="margin: 0; font-size: 0.8em;"><i>*For Yale College students on a medical leave of absence only*</i></p>			Return To: Yale Health Member Services Phone: 203.432.0246 email: member.services@yale.edu		
Last Name:		First Name:		Middle Name:	Date of Birth:
Home Address (street, city, state, zip code):					
Student ID Number (SID):		Sex:	Phone:		Email:
Membership and Cost Per semester <input type="checkbox"/> Single <input type="checkbox"/> Student plus spouse <input type="checkbox"/> Student plus child(ren) <input type="checkbox"/> Family–student plus spouse plus child(ren)					
Student Status <input type="checkbox"/> Leave of Absence (Undergraduate Affiliate Coverage)					
Rates <input type="checkbox"/> Single: \$4,414 per term <input type="checkbox"/> Student/spouse: \$8,002 per term <input type="checkbox"/> Student/child(ren): \$7,228 per term <input type="checkbox"/> Family (student/spouse/child(ren)): \$11,138					
Period of Enrollment for Undergraduate Affiliate Coverage*					
Selection	Length of Enrollment	Start Date	End Date		
<input type="checkbox"/>	Fall Term <u>only</u>	August 1, 2023*	January 31, 2024		
<input type="checkbox"/>	Spring Term <u>only</u>	February 1, 2024*	July 31, 2024		
*Students must request and complete enrollment into Undergraduate Affiliate Coverage within 30 days of the date the leave is granted.					
Method of Payment <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> SFAS Account <input type="checkbox"/> Other					
Enroll eligible spouse/civil union partner and/or dependents under 26 below: Last name, first name, middle Initial				Birth date 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 Yale Health coverage is effective? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which family members will be covered by other insurance? <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Children Name of Carrier _____ Address _____ Policy Number _____ Company through which coverage is obtained _____					
Agreement Students who elect to purchase Undergraduate Affiliate Coverage must also remain enrolled in Yale Health Hospitalization/Specialty Care coverage and are responsible for premium charges for the coverage as well as all copays, deductibles, coinsurance fees, and bills resulting from non-covered or partially covered services by Yale Health and Aetna. The premium due for the level of coverage (single, student plus spouse, student plus child/ren, family) you select will be billed to your Student Financial & Administrative Services (SFAS) account. Applicable copays, deductibles, coinsurance fees, and bills resulting from non-covered or partially covered services will be collected directly from you by the provider of service either at the time of service or afterwards. I have read the plan summary information, understand it, and wish to enroll in the Undergraduate Affiliate Coverage. I fully certify that the information provided is true and complete.					
Signature _____ Date _____					
FOR YALE HEALTH USE ONLY Effective Date _____ Database Update _____		Banner Status		GRP/PLN	
Change (if applicable) From: _____ To: _____					