2024 HEALTHCARE SUBSIDY FORM

□ **New Enrollment** □ **Change**

SECTION 1: To be completed by Fellow (within 10 days after appointment begins)

Last Name	First Name	
Address		
City	State	Zip
Home Phone	Work Phone	
Department	Date of Hire	

Health Enrollment Elections (please check one):

□ **Yale Health Plan** □ **Aetna Choice POS II** □ **Aetna Smart Care Plan**

□ **Employee** □ **Employee + Child(ren)** □ **Employee + Spouse** □ **Family**

SECTION 2: To be completed by Department

Departmental Authorization to Subsidize MEDICAL Coverage for Fellows (select one):

OPTION 1 Yale Health Plan Full Cost*:
□SINGLE $969 □EMPLOYEE + CHILD(REN) $1841 □EMPLOYEE + SPOUSE $2035 □FAMILY $2907

OPTION 2 Aetna Choice POS II Full Cost*:
□SINGLE $1242 □EMPLOYEE + CHILD(REN) $2360 □EMPLOYEE + SPOUSE $2608 □FAMILY $3726

OPTION 3 Aetna Smart Care Plan Full Cost*:
□SINGLE $886 □EMPLOYEE + CHILD(REN) $1655 □EMPLOYEE + SPOUSE $1818 □FAMILY $2587

OPTION 4 OTHER* (Please select if you elect to subsidize Aetna coverage at the Yale Health Rate or another flat amount)
□Flat Monthly Amount of $ ______________________

***All rates are subject to increases at the start of the calendar year.**

REMINDER:
The election indicated above is to be charged to the grant COA(s) and/or to department COA(s). "PDF Sub" earning should be scheduled at the worker position earning level when assigning Costing Allocations. If the worker position earning level schedule is not assigned it will be charged to the worker position level COA(s). Any premium difference for the medical coverage elected by the Fellow will be charged directly to the Fellows stipend check.

DEPARTMENT**: ____

SUBSIDY START DATE: _________________ SUBSIDY END DATE: _______________

Authorized by: (print full name)____Tel #_________________________

Signature:____Date: ________________

****PLEASE AUTHORIZE AND SUBMIT TO YOUR DEPARTMENT BY THE 15TH OF THE MONTH IN WHICH THE POSTDOCTORAL FELLOW'S APPOINTMENT BEGINS.**