

Princeton Healthcare Plan Election Form

Name (please print):		First		NAI.	
Last	Oneit	First		MI	
	Socia		er:		
Date of Birth://	Telephone Nu YYYY	ımber: <u>() </u>			
Address:Street					
Street		Apt/Building			
City	State/Country		Zip C	Code	
HEALTH CARE PLAN ELEC	CTION: Aetna Consumer Directe	d Health Plan (C	DHP)		
Check One	2019 Mc	onthly Premium			
CDHP Employee CDHP Employee CDHP Employee CDHP Employee Waive DEPENDENTS: Complete the	and Spouse \$455 and Child(ren) \$377	5.00 7.00 8.00	s) to be cover	ed under tl	he CDHP.
Name of Dependent (print first and last name)	Address (if different)	Relationship	Birthdate (Required)	Gender	Social Security Number (Required)
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				☐ M ☐ F	
				_	
benefit plan listed on this enro as defined under Princeton U disciplinary action. I understa salary on a pretax basis for p post-tax basis. In the event I of directly. I understand that I m reported to the Office of the F	and sign the following statemer ollment form. I attest that those inconiversity's plans. Any false misrepend that I will be charged a premiur remiums. I understand that contributed not receive a paycheck from Pray revoke this election only as perduman Resources. A new election in ninety (90) days if change is controlled.	dividuals covered oresentation on the most of the plan, are butions from any rinceton Universimitted by the ter n form must be	as dependent his enrollment to hid I authorize F non-salary pay ty, I understan- ms of the appli- completed by	is are in faction may reprince ton to when the common to the common the comm	t my dependents esult in reduce my be made on a eton will bill me fit plan and as
Signature:		Date:			
Princeton, and I elect not to re	and sign the following stateme eceive coverage for myself (and m I understand that I may revoke thi the applicable plan.	ny dependents, if	applicable). In	nstead I ele	ct coverage
Name of my non-Princeton	healthcare plan:				-
Signature:		Date:			