PRINCETON UNIVERSITY
HUMAN RESOURCES

Princeton Healthcare Plan Election Form

Name (please print):_____
Last First MI

Employee ID Number: _____

Date of Birth: _____/_____/_____ Telephone Number: (____)_____
MM DD YYYY Area Code

Address: _____
Street Apt/Building

_____
City State/Country Zip Code

HEALTH CARE PLAN ELECTION: Aetna Consumer Directed Health Plan (CDHP)

Check One		***2020 Monthly Premium***
☐	CDHP Employee Only	$206.00
☐	CDHP Employee and Spouse	$455.00
☐	CDHP Employee and Child(ren)	$377.00
☐	CDHP Employee and Family	$638.00
☐	Waive	n/a

DEPENDENTS: Complete the information below regarding the dependent(s) to be covered under the CDHP.

Name of Dependent (print first and last name)	**Address (if different)**	**Relationship**	**Birthdate (Required)**	**Gender**	**Social Security Number**
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	

If you elect coverage, read and sign the following statement: I hereby elect coverage under the Princeton University benefit plan listed on this enrollment form. I attest that those individuals covered as dependents are in fact my dependents as defined under Princeton University's plans. Any false misrepresentation on this enrollment form may result in disciplinary action. I understand that I will be charged a premium for the plan, and I authorize Princeton to reduce my salary on a pretax basis for premiums. I understand that contributions from any non-salary payments will be made on a post-tax basis. In the event I do not receive a paycheck from Princeton University or if my pay is not enough to cover the cost of the plan, I understand that Princeton will bill me directly. I understand that I may revoke this election only as permitted by the terms of the applicable benefit plan and as reported to the Office of the Human Resources. ***If I experience a Qualifying Status Event, a new election form must be completed within thirty-one (31) days of the change or within ninety (90) days if the change is due to birth or adoption of a child.***

Signature:_____ **Date:** _____

If you waive coverage, read and sign the following statement: I fully understand the terms of coverage provided by Princeton, and I elect not to receive coverage for myself (and my dependents, if applicable). Instead I elect coverage under a non-Princeton plan. I understand that I may revoke this election and elect coverage under a Princeton plan only as permitted by the terms of the applicable plan.

Name of my non-Princeton healthcare plan: _____

Signature: _____ **Date:** _____