Princeton University, Office of Human Resources
100 Overlook Center, Suite 400, Princeton, NJ 08540

Princeton Health Care Plan Election Form for Retirees Under Age 65

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 PLAN ELECTION:

Check One: For OHR Office Use:

- ☐ **UnitedHealthcare Princeton Health Plan** [RETUPH]
- ☐ **Aetna Princeton Health Plan** [RETAPH]
- ☐ **Aetna HMO** [RETHMO]
- ☐ **Waiver***

* I understand that if I waive coverage or remove a dependent that I am **not eligible** to enroll myself or a dependent into the Plan at a later time. I also understand that I cannot enroll a new dependent at a later time.

VISION ELECTION: Once enrolled, you may not terminate your coverage mid-year

Check One: For OHR Office Use:

- ☐ **MetLife Vision Plan** [RETVCP]
- ☐ **Waiver**

Dependent Information: If dependent coverage is requested, please provide the following information and check the box (medical and/or vision) to assign your dependent(s) to that plan:

Name of Dependent	Date of Birth (Required)	Social Security Number (Required)	Medicare ID Number*	Relationship	Medical	Vision

*Only applicable if your spouse is Medicare eligible.

Spouse's Age as of Coverage begin Date: My spouse is: ☐ Under age 65 ☐ Age 65 or Over

I have elected or waived coverage of the Princeton University benefit plans, which I have selected on this enrollment form. I attest that those individuals covered as dependents are in fact my dependents as defined under Princeton University's Plans, if applicable. I understand that I will be billed directly for the coverage, where applicable. I understand that if I waive coverage or remove a dependent that I am ineligible to enroll myself or a dependent into the retiree medical plan at a later time; nor can I enroll a new dependent at a later time.

I understand that I may revoke this election only as permitted by the terms of the applicable benefit plans.

Signature:_____ Date:_____

RATE INFORMATION ON REVERSE

2021 Retiree Health Care Plan Monthly Premiums
For Retirees Under Age 65

Health Care Plan	Retiree Only	Retiree and Child(ren)	Retiree and Spouse	Retiree and Family
Aetna or UnitedHealthcare Princeton Health Plan Retiree under 65 and Spouse (if applicable) under 65	$183.00	$505.00	$640.00	$946.00
Aetna or UnitedHealthcare Princeton Health Plan Retiree under 65 and Spouse (if applicable) over 65	$183.00	$505.00	$457.00	$763.00
Aetna HMO Retiree under 65 and Spouse (if applicable) under 65	$122.00	$359.00	$481.00	$738.00
Aetna HMO Retiree under 65 and Spouse (if applicable) over 65	$122.00	$359.00	$359.00	$616.00
Vision – both over & under 65				
MetLife Vision Plan	$14.19	$26.00= (& 1 child*)	$26.00	$33.31

*If you are enrolling more than one child, you must elect Retiree and Family