



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)

<i>Check One</i>	<i>2021 Monthly Premium</i>
<input type="checkbox"/> CDHP Employee Only	\$206.00
<input type="checkbox"/> CDHP Employee and Spouse	\$455.00
<input type="checkbox"/> CDHP Employee and Child(ren)	\$377.00
<input type="checkbox"/> CDHP Employee and Family	\$638.00
<input type="checkbox"/> 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
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> 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:** _____