COLUMBIA UNIVERSITY
HR Benefits

Medical Plan Election Form for Under Age 65 Retired Officers

Please complete this form, then sign and date. **Enrollment Effective _____**	**Mail return this form to the Benefits Service Center** **hrbenefits@columbia.edu**

Last Name:		**First Name:**	
CU ID Number or UNI:		**Date of Birth:**	
Mailing Address:			
Email Address:			
Telephone Number:	– –	**Retirement Date:**	

Under Age 65 Medical Plan Options

- ☐ **Choice Plus 80**
- ☐ **Choice Plus 90**
- ☐ **Choice Plus 100**

COVERAGE LEVEL: Please check all boxes that apply to the Under Age 65 Medical Plan elected

- ☐ **Yourself**
- ☐ **Spouse/Same-Sex Domestic Partner***
- ☐ **Dependent Child(ren)**
- ☐ **Surviving Dependent of University Retiree**
- ☐ **Family Coverage**

☐ **I elect to decline coverage at this time, effective: _____**

By declining I permanently forfeit my eligibility.

Columbia University reserves the right to change, amend, or terminate any benefit plan as it deems appropriate. This notice in no way guarantees or implies that Columbia University's retiree medical plans will continue into the future nor does it guarantee or imply that the coverage and/or costs will remain the same in the future.

Dependent Information

Only the spouse/same-sex domestic partner named as your dependent when you retired will be eligible for medical benefits when you retire. However, you may add new dependent children to your coverage. Dependent children can be covered until age 19, or until age 26 if a full-time student. Enter information for all dependents you will cover. You must provide proof of each dependent's eligibility if selected for an audit.

*If you are currently enrolled in domestic partner coverage and you enroll in benefits for 2026, you will continue to receive same-sex domestic partner benefits.

Dependent #1: Name:		**Gender:**
Social Security Number: Call Benefits Service Center	**Relationship:**	**Date of Birth:** – –
Dependent #2: Name:		**Gender:**
Social Security Number: Call Benefits Service Center	**Relationship:**	**Date of Birth:** – –

I understand that when I and any dependents become eligible for Medicare, we must enroll in Medicare Part A and Part B as our primary insurer. I understand that if I waive my Columbia University Retiree Medical Coverage at this time, future eligibility will be determined upon the terms of the retiree medical plan in effect at the time.

Retiree Signature: _____ ***Date (mm/dd/yyyy):*** _____