



WWW.ASA.EDU

HEALTH INSURANCE ACCEPTANCE FORM 2018-2019 FOR FULL TIME (FT) EMPLOYEES

EMPLOYEE INFORMATION

Name (Last, First):	Employee ID:
Home Address:	Date of Hire:
Telephone #:	SSN#:
E-mail address:	Date of Birth:
Signature:	Gender:

I elect Health Insurance coverage for 2018-2019 as follows:

HEALTH INSURANCE INFORMATION

Employee Pre-Tax Bi-Weekly Payroll Deductions

(please check the box next to cost for your benefit selection below and initial)

	High EPO Plan		Low EPO H.S.A. Plan		Medicare (Age 65+ Only)		Guardian Vision PPO*		Guardian Dental*			
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	PPO		HMO*	
Employee:	\$109.23	<input type="checkbox"/>	\$69.91	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	\$2.43	<input type="checkbox"/>	\$21.92	<input type="checkbox"/>	\$6.32	<input type="checkbox"/>
Employee/Spouse:	\$486.34	<input type="checkbox"/>	\$405.61	<input type="checkbox"/>	SEE CHART IN PACKET	<input type="checkbox"/>	\$3.69	<input type="checkbox"/>	\$42.62	<input type="checkbox"/>	\$11.48	<input type="checkbox"/>
Employee/1 Child:	\$486.34	<input type="checkbox"/>	\$405.61	<input type="checkbox"/>		<input type="checkbox"/>	\$3.69	<input type="checkbox"/>	\$42.62	<input type="checkbox"/>	\$11.48	<input type="checkbox"/>
Employee/Children:	\$920.01	<input type="checkbox"/>	\$791.66	<input type="checkbox"/>	SEE CHART IN PACKET	<input type="checkbox"/>	\$6.49	<input type="checkbox"/>	\$72.90	<input type="checkbox"/>	\$20.73	<input type="checkbox"/>
Family:	\$920.01	<input type="checkbox"/>	\$791.66	<input type="checkbox"/>		<input type="checkbox"/>	\$6.49	<input type="checkbox"/>	\$72.90	<input type="checkbox"/>	\$20.73	<input type="checkbox"/>
Waiver: **	\$0.00	<input type="checkbox"/> **	\$0.00	<input type="checkbox"/> **	\$0.00	<input type="checkbox"/> **	\$0.00	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>

**Requires FT Medical DECLINATION Form SUBMISSION, if waiving.

MDG Dentist Code # (for HMO Dental Plan enrollees)*: Self Spouse Children

*To find participating dentists for HMO dental plan, please go to www.guardiananytime.com. Then, enter the dentist's code number.

If insuring family members, enter their information below:

DEPENDENT INFORMATION

Dependent #1		Date of Birth:
Name (Last, First):		
Relationship:	Gender:	SSN#
Dependent #2		Date of Birth:
Name (Last, First):		
Relationship:	Gender:	SSN#
Dependent #3		Date of Birth:
Name (Last, First):		
Relationship:	Gender:	SSN#
Dependent #4		Date of Birth:
Name (Last, First):		
Relationship:	Gender:	SSN#

ASA College Human Resources Office

Received Date

HR Assistant Name and Title

HR Assistant Signature

DOWNTOWN BROOKLYN

151 Lawrence Street
Brooklyn, NY 11201
Tel: 718 - 522-9073

MIDTOWN MANHATTAN

1293 Broadway/One Herald Center
New York, NY 10001
Tel: 212-672-6450

NORTH MIAMI BEACH

3909 N.E. 163rd Street
North Miami Beach, FL 33160
Tel: 786-279-1740

DANIA BEACH

225 E Dania Beach Blvd, Suite 120
Dania Beach, FL 33004
Tel: 786-279-1740

HIALEAH

530 West 49th Street
Hialeah, FL 33012
Tel: 786-279-2643