



# HEALTH INSURANCE DECLINATION FORM FOR FULL-TIME (FT) EMPLOYEES

## EMPLOYEE INFORMATION

Name (Last, First): \_\_\_\_\_

Employee #:

Department: \_\_\_\_\_

Title: \_\_\_\_\_

## ASA College Health Insurance Coverage Plan

- CIGNA - Trad. EPO - HIGH PLAN
- CIGNA - H.S.A. - LOW PLAN
- Medicare+ Gap Plans - age 65+

I \_\_\_\_\_ certify that I am declining insurance coverage through the ASA Health Insurance Coverage Plan.

I understand that this declination also eliminates dependent eligibility through this plan.

If I choose to accept this policy in the future, coverage will not be available until the next open enrollment, following that decision.

I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.

Employee's Signature: \_\_\_\_\_

\_\_\_\_\_ Date

## 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