ASA COLLEGE

WWW.ASA.EDU

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I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.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