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HEALTH INSURANCE DECLINATION FORM FOR FULL TIME EQUIVALENT (FTE) EMPLOYEES

(for employees working 30-39 hours per week)

EMPLOYEE INFORMATION

Name: _____ Employee #: _____

Department: _____

Title: _____

ASA College Health Insurance Coverage Plan

CIGNA - MVP H.S.A.

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I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.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