ASA COLLEGE

WWW.ASA.EDU

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I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.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