ASA COLLEGE

WWW.ASA.EDU

2019-2020 DENTAL AND VISION INSURANCE DECLINATION FORM

EMPLOYEE INFORMATION

Name *(Last, First)*: _____ Employee #: _____

Department: _____

Title: _____

ASA College Dental and Vision Insurance Coverage Plan

- ❑ Guardian Dental PPO Plan
- ❑ Guardian Dental HMO Plan
- ❑ Guardian Vision PPO Plan

I _____ certify that I am declining Dental and/or Vision coverage through the ASA Dental and Vision 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I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.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