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2021-2022 HEALTH INSURANCE DECLINATION FORM
FOR FULL-TIME (FT) EMPLOYEES

EMPLOYEE INFORMATION

Name: _____ 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 _____ acknowledge that I have received and reviewed the offer of healthcare benefits made to me by ASA College and will be 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, absent a Qualifying Event. I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.

I understand that my employer has ensured that the benefit plan offered meets or exceeds standards set under the Affordable Care Act to qualify as a Minimum Value Plan. Further, I understand that my employer has ensured that my required contribution cost via payroll deductions will not exceed the level at which premiums would be deemed unaffordable to me under the terms of the Affordable Care Act for single coverage. I understand that because my employer has made an affordable offering to me for coverage that meets MVP standards, it may legally disqualify me from any Federal Tax Credit that may have otherwise been available to me through the State or Federal Healthcare Marketplace. I understand that if I enroll on a Marketplace plan with a Federal tax credit, that required Employer annual reporting may result in the IRS recouping the tax credit from any future tax refund.

Employee's Signature:

_____ _____
Date

ASA College Human Resources Office

_____ _____
Received Date HR Assistant Name and Title

_____
HR Assistant Signature