



WWW.ASA.EDU

2019-2020 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I understand that this declination will remain in force until rescinded in writing and submitted to the ASA College Human Resources Office.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

HIALEAH
530 West 49th Street
Hialeah, FL 33012
Tel: 786-279-2643