WWW.ASA.EDU

2021-2022 INSURANCE BENEFITS ELECTION FORM
FOR FULL TIME (FT) EMPLOYEES

EMPLOYEE INFORMATION

Name *(Last, First)*:			**Employee ID:**
Home Address: *(Include City, State, Zip)*			**Date of FT Hire:**
Telephone #:			**SS#:**
E-mail address:	**Gender:**	**Salary:**	**Date of Birth:**

HEALTH INSURANCE INFORMATION

Initial enrollment eligibility after 90 days of FT employment | **Employee Pre-Tax Bi-Weekly Payroll Deductions**

Please mark your selection for each benefit below. Please check the box next to cost of your plan & initial. I elect (or waive) coverage for 2021-22 as follows:

	Cigna (Medical + HRA)														Guardian Accident Plan	
	High Plan Trad. EPOc		Low Plan		Medicare (Age 65+ Only)		Guardian Vision PPO Plan		Guardian Dental PPO Plan		Guardian Dental HMO Plan*					
Employee:	$133.00	☐	$100.00	☐	$0.00	☐	$2.51	☐	$28.45	☐	$6.32	☐	$3.44	☐		
Employee/Spouse:	$520.00	☐	$414.00	☐	YOU PAY ADDED COST FOR SPOUSE	☐	$3.80	☐	$55.32	☐	$11.48	☐	$5.63	☐		
Employee/1 Child:	$520.00	☐	$414.00	☐		☐	$3.80	☐	$55.32	☐	$11.48	☐	$5.67	☐		
Employee/Children:	$966.00	☐	$800.00	☐		☐	$6.69	☐	$94.63	☐	$20.73	☐	$5.67	☐		
Family:	$966.00	☐	$800.00	☐		☐	$6.69	☐	$94.63	☐	$20.73	☐	$7.86	☐		
Decline / Waiver:**	$0.00	☐	$0.00	☐	$0.00	☐	$0.00	☐	$0.00	☐	$0.00	☐	$0.00	☐		

***Note: If waiving Medical and/or Dental and/or Vision coverage, you must also complete ASA waiver forms.*

MDG Dentist Code # (for HMO Dental Plan enrollees)*: **Self** _____ **Spouse** _____ **Children** _____

To find participating dentists for HMO dental plan, please go to www.guardiananytime.com. Then,* ***enter the dentist's code number**.*

ASA PAID BENEFITS (NO COST TO YOU)

Long Term Disability:	☐	**60% of salary. $5,000/month Max. benefit. 180 day Elimination Period.**
Basic Life Ins/AD&D:	☐	**100% of salary. $100,000 Max. benefit.** **Enter Beneficiary details below.**

Beneficiary Name	Beneficiary Address	Telephone #	Social Security #	Relationship	%	Date of Birth

ADDITIONAL BENEFITS***

Voluntary Life & Critical illness rates vary by age & amount elected. See separate packet for benefit details/rates.

Voluntary Life: ☐ Elect ☐ Decline | **Critical Illness Plan:** ☐ Elect ☐ Decline | ****If electing any of these benefits, please complete separate Guardian enrollment form(s).*

DEPENDENT INFORMATION

Enter details below for any dependents (Spouse and/or children) only if insuring them for any benefits.

Dependent #1 Name *(Last, First):*		Date of Birth:
Relationship:	Gender:	SS#
Dependent #2 Name *(Last, First):*		Date of Birth:
Relationship:	Gender:	SS#
Dependent #3 Name *(Last, First):*		Date of Birth:
Relationship:	Gender:	SS#

_____ **Signature** _____ **Date** _____ **ASA College Human Resources Office (Date rec'd)**