ASA COLLEGE

WWW.ASA.EDU

2019-2020 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:**	**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 2019-20 as follows:

	Cigna Opt. #1 Trad. EPOc		Cigna Opt. #2 H.S.A. Plan		Medicare (Age 65+ Only)		Guardian Vision PPO Plan		Guardian Dental PPO Plan		Guardian Dental HMO Plan*		See separate packet for additional, Voluntary Benefit options. Life Insurance, Accident plan & Critical Illness plan.
Employee:	$118.23	❑	$78.91	❑	$0.00	❑	$2.43	❑	$22.39	❑	$6.32	❑	
Employee/Spouse:	$495.34	❑	$414.61	❑	YOU PAY ADDED COST FOR SPOUSE	❑	$3.69	❑	$43.54	❑	$11.48	❑	
Employee/1 Child:	$495.34	❑	$414.61	❑		❑	$3.69	❑	$43.54	❑	$11.48	❑	
Employee/Children:	$929.01	❑	$800.66	❑		❑	$6.49	❑	$74.48	❑	$20.73	❑	
Family:	$929.01	❑	$800.66	❑		❑	$6.49	❑	$74.48	❑	$20.73	❑	

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.*

DEPENDENT INFORMATION

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#
Dependent #4 Name *(Last, First):*		Date of Birth:
Relationship:	Gender:	SS#

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

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151 Lawrence Street
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