United Nations
Health & Life Insurance Section

Application for After Service Health Insurance (ASHI) & Pension Fund Deduction of Premiums

UN Secretariat staff shall submit the completed form to: Health and Life Insurance Section (HLIS), Email: ashi@un.org

Other staff shall submit the completed form in accordance with instructions under the ASHI application checklist on HLIS website

SECTION 1 - Applicant Information[1] (*Please print all information clearly*)

Name *(Last, First):*	Payroll Index Number:	Pension Number:
Full Mailing Address:	Date of Birth: *(DD/MM/YYYY)*	Marriage Date: (DD/MM/YYYY)
	Nationality:	Country of Residency: (After retirement)
	Permanent Resident of the US: ☐ Yes ☐ No	US Residency Start Date: (DD/MM/YYYY)
Are you currently on a G4 visa? ☐ Yes ☐ No	Will you be applying for permanent residency of the US? ☐ Yes ☐ No	
Personal Telephone Number:	Personal Email Address (Not a UN Email Address):	
If your spouse is ☐ an active staff member or ☐ a retiree of a UN system organization, please provide their full name _____, payroll index number _____, and the name of the employing organization _____	My spouse is a staff member or retiree ☐ Not participating in a health plan of a UN system organization ☐ Participating in a health plan of a UN system organization, and has been enrolled in a health plan of a UN system organization for the past _____ years	

Emergency Contact Details:		
_____ (Full Name & Relationship)	_____ (Personal Email Address)	_____ (Personal Telephone Number)
_____ (Full Mailing Address)		

Are you separating from the UN Secretariat? ☐ Yes ☐ No	If not UN Secretariat, please specify your employing organization:	Duty Station:	Category and Grade:
Date of Separation/Retirement: *(if former staff member is deceased, Date of Death)* *(DD/MM/YYYY)*			

[1] It is important that you inform HLIS immediately if your mailing address, email address or telephone number change.

Have you worked in other UN Organizations in whose health insurance schemes you were covered? ☐ Yes ☐ No	Please indicate names and years of service:	
	Organization:	Years of Service:
	1.	
	2.	
	3.	

If additional space is needed, please attach a separate page that includes the additional information.

Please check appropriate box:

☐ Regular retirement at normal retirement age (60, 62 or 65)

☐ Early retirement

☐ Disability (must attach benefit confirmation letter from UNJSPF)

☐ Widow/Widower/Orphan (must attach benefit confirmation letter from UNJSPF. Please note that widows/widowers will lose coverage upon re-marriage)

Please check the box that best describes your situation (you may check only one box):

☐ I will be receiving a monthly pension benefit from the UNJSPF upon my separation from service.

☐ I am choosing to elect a deferred retirement benefit from the UNJSPF.
Important: If you elect a deferred retirement benefit you must pay premiums in advance for the period in which you will not receive monthly UNJSPF benefits. Furthermore, you must attach to your ASHI application the pension estimate from the UNJSPF showing the amount of your full deferred retirement benefit (i.e. unreduced pension benefit). The application cannot be processed without this estimate.

☐ I am choosing to defer my choice of UNJSPF benefit between deferred retirement benefit and withdrawal settlement.
Important: If you elect to defer your choice of UNJSPF benefit you will not be eligible for ASHI. Also electing a full withdrawal settlement from the UNJSPF (without receiving any monthly UNJSPF pension benefit) makes a retiring staff ineligible for ASHI.

SECTION 2 – Dependant(s) to be enrolled in your ASHI

Spouse[2]	Name *(Last, First):*	Gender: ☐ M ☐ F ☐ Other	Date of Birth: *(DD/MM/YYYY)*	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No		Residency Start Date: *(DD/MM/YYYY)*

Child	Name *(Last, First):*	Gender: ☐ M ☐ F ☐ Other	Date of Birth: *(DD/MM/YYYY)*	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No		Residency Start Date: *(DD/MM/YYYY)*
Please check if applicable: ☐ Entitled to UNJSPF child's disability benefit *(must attach benefit confirmation letter from UNJSPF)*				

Child	Name *(Last, First):*	Gender: ☐ M ☐ F ☐ Other	Date of Birth: *(DD/MM/YYYY)*	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No		Residency Start Date: *(DD/MM/YYYY)*
Please check if applicable: ☐ Entitled to UNJSPF child's disability benefit *(must attach benefit confirmation letter from UNJSPF)*				

[2] For staff members that are married to each other and have insurance coverage at the two-person or family level: if one spouse retires from the service of the UN before the other spouse, the spouse remaining in active service must become the subscriber. To reserve the right for ASHI, the retiring staff must submit a timely Application for ASHI even though the spouse in active service will become the subscriber.

Child	Name *(Last, First):*	Gender: ☐ M ☐ F ☐ Other	Date of Birth: *(DD/MM/YYYY)*	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No		Residency Start Date: *(DD/MM/YYYY)*
Please check if applicable: ☐ Entitled to UNJSPF child's disability benefit *(must attach benefit confirmation letter from UNJSPF)*				

If additional space is needed, please attach a separate page that includes the additional information.

Important: If the retiree pre-deceases the dependant(s) covered under their ASHI, the covered dependant(s) must contact HLIS within maximum three-months from the retiree's death to ensure continuation of their coverage. Continuation of coverage is possible only if the survivors were covered under the retiree's ASHI at the time of the retiree's death and are eligible for a periodic benefit from the UNJSPF or under Appendix D.

SECTION 3 - Health Insurance Elections

☐ Aetna PPO	☐ Anthem Blue Cross PPO	☐ Cigna Dental PPO*	☐ UN Worldwide Plan (administered by Cigna Health Care)**	☐ HIP***

**If you select Aetna PPO, Empire Blue Cross PPO or HIP please make sure to also select Cigna Dental PPO if you wish to have dental coverage.*
***If you select UN Worldwide Plan, please note that the Plan already includes dental coverage, and you will not be able to select Cigna Dental PPO. The UN Worldwide plan is not recommended for those that reside in the US or would like to seek treatment in the US.*
****HIP is a closed plan, and it is only available to subscribers who had it as a medical plan during active service.*

SECTION 4 - Medicare Information[3]

Complete if you or any dependants are covered by Medicare.

Name of Person Covered:		Relationship to ASHI Participant:		MBI Number (From Medicare Card):
Medicare Part A (Hospital)		**Medicare Part B (Medical)**		
Start Date: *(DD/MM/YYYY)*	End Date: *(DD/MM/YYYY)*	Start Date: *(DD/MM/YYYY)*	End Date: *(DD/MM/YYYY)*	

Name of Person Covered:		Relationship to ASHI Participant:		MBI Number (From Medicare Card):
Medicare Part A (Hospital)		**Medicare Part B (Medical)**		
Start Date: *(DD/MM/YYYY)*	End Date: *(DD/MM/YYYY)*	Start Date: *(DD/MM/YYYY)*	End Date: *(DD/MM/YYYY)*	

If additional space is needed, please attach a separate page that includes the additional information.

Please note that all applicable fields in this three-page form should be filled, or the application will not be processed.

Please read the Administrative Instruction on After-Service Health Insurance, as well as other relevant policy documents. The documents can be found on the HLIS website at https://www.un.org/insurance

Pension Fund Authorization *(please sign the form and write out the date it was signed)*

I hereby authorize the UNJSPF to deduct from my monthly pension benefit, and to remit directly to the UN, the premium contribution for my ASHI coverage. I also authorize the UNJSPF to provide from time to time, as required, to the office(s) of the organization responsible for administering the health insurance scheme, information on the status and amount of my pension and its basis of calculation, as may be required to administer my insurance coverage.

_____ _____

Applicant's Signature | Date Signed (DD/MM/YYYY)

[3] You are eligible for Medicare Part B if you are 65 years or older, and are a US citizen or permanent resident who has been lawfully residing in the US for a minimum of 5 years, including periods under a G4 visa. For more information on the mandatory enrollment requirements for Medicare Part B, please visit our website at www.un.org/insurance.