United Nations
Health & Life Insurance Section

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

Please submit the completed form to: Health and Life Insurance Section (HLIS),
Email: ashi@un.org – Fax (917) 367-1670

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

Name *(Last, First):*	Payroll Index Number:	Pension Number:
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:
Are you currently on a G4 visa? ☐ Yes ☐ No	Will you be applying for permanent residency of the US? ☐ Yes ☐ No	

Organization:		If non-UN, please specify subsidizing agency:	
Duty Station:	Category and Grade:	Telephone Number:	Personal Email:

Date of Separation/Retirement: *(if former staff member is deceased, Date of Decease)*	Please check appropriate box: ☐ Regular Retirement at 60, 62 or 65 ☐ Early Retirement ☐ Widow*/Widower*/Orphan ☐ Disability *(must attach letter from Pension Fund)* * Please note that you will lose this coverage upon re-marriage
If pension is deferred, or if no election is made, please attach the pension estimate from the Pension Fund reflecting full/unreduced pension. The application can NOT be processed without this estimate	Are you deferring your pension? ☐ Yes ☐ No Will you be receiving a monthly pension benefit from UNJSPF? ☐ Yes ☐ No

SECTION 2 - Dependant Coverage

***IMPORTANT:** If covered spouse was a former staff member, the higher-pensioned retiree must carry the insurance in ASHI and submit this application form.*

Spouse	Name *(Last, First)*:		Gender: ☐ M ☐ F ☐ Other	Date of Birth:	Nationality:
Country of Residency:	Permanent Resident of the US: ☐ Yes ☐ No	US Residency Start Date:	If spouse is/was a s/m, provide Index # below:	Number of years of Participation in a UNHQ administered health plan:	

Child	Name *(Last, First)*:	Gender: ☐ M ☐ F ☐ Other	Date of Birth:	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No	Residency Start Date:	
Number of years of Participation in a UNHQ administered health plan:		Please check if applicable: ☐ Entitled Disability *(must attach letter from Pension Fund)*		

Please complete the other side.

Child	Name *(Last, First)*:	Gender: ☐ M ☐ F ☐ Other	Date of Birth:	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No	Residency Start Date:	
Number of years of Participation in a UNHQ administered health plan:		Please check if applicable: ☐ Entitled Disability *(must attach letter from Pension Fund)*		

Child	Name *(Last, First)*:	Gender: ☐ M ☐ F ☐ Other	Date of Birth:	Nationality:
Country of Residence:		Permanent Resident? ☐ Yes ☐ No	Residency Start Date:	
Number of years of Participation in a UNHQ administered health plan:		Please check if applicable: ☐ Entitled Disability *(must attach letter from Pension Fund)*		

If additional space for dependants is needed, please attach another form.

SECTION 3 - Health Insurance Elections

☐ Aetna PPO ☐ Empire Blue Cross PPO ☐ Cigna Dental PPO* ☐ UN WWP ☐ HIP

**If you select Aetna PPO or Empire Blue Cross PPO, please make sure to also select Cigna Dental PPO if you want dental coverage.*

SECTION 4 - Medicare Information

Complete if you or any dependants are covered by Medicare. (Please attach another form if more space is needed.)

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

SECTION 5 – National Insurance Eligibility

Complete if you or any dependants are/will be eligible for national insurance. (Please attach another form if more space is needed.)

Will you or your dependant(s) be eligible for Medicare Part A? ☐ Yes ☐ No

Will you or your dependant(s) be eligible for Medicare Part B*? ☐ Yes ☐ No

**You are eligible for Part B if you 65 years or older and have been lawfully residing in the US for 5 years.*

Name of Person:	Name of the National Insurance:	Country:
	Start Date:	End Date:

Please note that all applicable fields should be filled, or the application will not be processed.

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

I hereby authorize the United Nations Joint Staff Pension Fund (UNJSPF) to deduct from my monthly pension benefit, and to remit directly to the United Nations, the premium contribution for my After Service Health Insurance Coverage. I also authorize 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 amount of my pension and its basis of calculation, as may be required for determination of the insurance premium.

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Applicant's Signature Date Signed *(Day/Month/Year)*