ACTION:	CODED BY:	DATE:

United Nations
Health & Life Insurance Section

GROUP MEDICAL & DENTAL INSURANCE

APPLICATION / REQUEST FOR CHANGE

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

1. EMPLOYED BY: ☐UN Secretariat ☐ UNDP ☐UNICEF ☐UNOPS ☐OTHER _____ ***(MUST SELECT ONE)***	2. LAST NAME: _____ 3. FIRST NAME: _____	4. DATE OF BIRTH *(DD/MM/YY)*: _____/_____/_____ Day Month Year	5. SEX: ☐M ☐F ☐Other	6. INDEX No.:

7. MAILING ADDRESS: _____
(Street) (Apt. #) (City) (State) (Zip Code)

PLEASE NOTE: Your current mailing address must be reflected in Umoja, Atlas, SAP or oneUNOPS, as applicable, in order to receive insurance cards, reimbursement cheques and other insurance administrator communications. Please see the back of this form for more details.

8. OFFICE ROOM No.	9. OFFICE TEL. No.:	10. OFFICE E-MAIL:	11. GRADE/LEVEL:

12. TYPE OF CONTRACT: ☐ PERMANENT ☐ CONTINUING ☐ FIXED TERM ☐ TEMPORARY

FOR FIXED TERM AND TEMPORARY APPOINTMENTS: CONTRACT FROM: _____ TO: _____

13. IF SPOUSE IS EMPLOYED BY THE UNITED NATIONS OR UN AGENCY PLEASE INDICATE BELOW:

NAME: _____ INDEX No.: _____ OFFICE/DEPT.: _____ GRADE/LEVEL: _____

APPLICATION/CHANGE REQUEST FOR **MEDICAL** ☐ YES ☐ NO	APPLICATION/CHANGE REQUEST FOR **DENTAL** ☐ YES ☐ NO
14. PLEASE CHECK AS APPROPRIATE: ☐ NEW **MEDICAL** COVERAGE ☐ TRANSFERRED FROM: Dept./Org.: _____ ☐ RE-INSTATEMENT AFTER BREAK IN SERVICE) ☐ RETURN FROM SPECIAL LEAVE WITHOUT PAY (SLWOP): ☐ ADD SPOUSE/CHILD(REN) *(as listed in item 18 below)* ☐ DELETE SPOUSE/CHILD(REN) *(as listed in item 18 below)* ☐ TERMINATE **MEDICAL** COVERAGE	16. PLEASE CHECK AS APPROPRIATE: ☐ NEW **DENTAL** COVERAGE ☐ TRANSFERRED FROM: Dept./Org.: _____ ☐ RE-INSTATEMENT AFTER BREAK IN SERVICE ☐ RETURN FROM SPECIAL LEAVE WITHOUT PAY (SLWOP) ☐ ADD SPOUSE/CHILD(REN) *(as listed in item 18 below)* ☐ DELETE SPOUSE/CHILD(REN) *(as listed in item 18 below)* ☐ TERMINATE **DENTAL** COVERAGE
15(a). **MEDICAL** PLAN: ☐ **AETNA** PPO ☐ EMPIRE **BLUE CROSS** PPO ☐ **HIP**/HMO *(if already enrolled)*	15(b). TYPE OF **MEDICAL** COVERAGE: ☐ STAFF MEMBER ONLY ☐ STAFF MEMBER & SPOUSE ☐ STAFF MEMBER & ONE CHILD ☐ FAMILY (three or more persons)
17 (a). **DENTAL** PLAN: ☐ **CIGNA DENTAL PPO**	17(b). TYPE OF **DENTAL** COVERAGE: ☐ STAFF MEMBER ONLY ☐ STAFF MEMBER & SPOUSE ☐ STAFF MEMBER & ONE CHILD ☐ FAMILY (three or more persons)

18. LIST BELOW SPOUSE & CHILDREN LAST NAME	FIRST NAME	SEX M F	RELATIONSHIP Spouse/Son/Daughter	DATE OF BIRTH Day/Month/Year	PLEASE CHECK APPROPRIATE BOX **ADD**		**DELETE**	
		☐ ☐			☐Medical	☐Dental	☐Medical	☐Dental
		☐ ☐			☐Medical	☐Dental	☐Medical	☐Dental
		☐ ☐			☐Medical	☐Dental	☐Medical	☐Dental
		☐ ☐			☐Medical	☐Dental	☐Medical	☐Dental
		☐ ☐			☐Medical	☐Dental	☐Medical	☐Dental
		☐ ☐			☐Medical	☐Dental	☐Medical	☐Dental

19. FOR NEW COVERAGE & ADDITION OF DEPENDANTS, PLEASE INDICATE BELOW:

☐ I WISH THE COVERAGE TO START ON THE ELIGIBILITY DATE (Appointment date/entry on duty; date of marriage; birth or adoption of child)

☐ I WISH THE COVERAGE TO START ON THE FIRST OF THE MONTH FOLLOWING THE ELIGIBILITY DATE.

Please complete form on the next page

20. MARRIAGE DATE *(Day/Month/Year)*: _____/_____/_____ Day Month Year	**PLEASE NOTE: Spouse and child(ren) must be registered in the respective organization's ERP system as household members. A child who is neither married nor employed full time is eligible to be insured until the end of the calendar year in which the child reaches the age of 25.**

21. I hereby authorize my Organization to make deductions from my salary appropriate to the type of insurance plan requested. I certify that the information provided above is correct.

DATE (*Day/Month/Year*): _____ SIGNATURE: _____

NOTES FOR APPLICANTS

Application for enrollment in one of the UNHQ administered health plans must be made within 31 days of becoming eligible for the coverage.

Staff members who do not make changes to their plans within 31 days of their eligibility dates, may do so ONLY during the ANNUAL ENROLLMENT CAMPAIGN held during the month of June.

ENROLLMENT

Staff members are eligible to join one of the UNHQ administered health plans upon the following qualifying work events:

- Receipt of an initial continuing or fixed term appointment
- Receipt of a temporary appointment for 3 months or longer
- Transfer of duty stations with an appointment of 3 months or longer
- Reappointment or reinstatement
- Transfer or secondment to organization participating in the UNHQ administered plans

CHANGES/TERMINATIONS

Addition of Dependants:

- Upon marriage, birth or legal adoption of a child. A completed application for enrollment must be received by HLIS within 31 days of the event giving rise to eligibility to enroll.

Deletion of Dependants:

- A spouse and/or child may be deleted from the coverage upon the staff member's written request. Any related change in the type of coverage will become effective on the first of the month following receipt of the written request.

Termination of Coverage:

- Voluntary termination of medical and/or dental coverage for a staff member and/or their covered dependant(s) can only be requested during the annual enrollment campaign or within 31 days of return from Special Leave Without Pay
- Upon divorce from spouse
- Upon either marriage or full-time employment of covered child
- Upon decease of a family member
- At the end of the calendar year in which a dependent child attains age 25

REQUIREMENTS

Proof of Contractual Status:

- If personnel action has not been completed in the respective organization's ERP system, a copy of a Letter of Appointment, travel authorization or other official document clearly stating the type of appointment, duration and effective date must be submitted with the application for enrolment in the health insurance plans.

Proof of Household Member Status:

- Household member record must be reflected in Umoja, ATLAS, SAP or oneUNOPS with effective date of recognition no later than 1 July 2021.