



**RETURN TO AFTER SERVICE HEALTH INSURANCE (ASHI)  
COVERAGE & AUTHORIZATION FOR DEDUCTION OF MONTHLY  
PREMIUM CONTRIBUTION FROM UNJSPF PERIOD BENEFIT**

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

**\*Please Note: A copy of separation personnel action [PA] must be attached to this form. Your return to ASHI coverage cannot be changed and must be at the same level of coverage as before (family, participant and spouse; participant only).**

Name (Last, First): _____	Pension Benefits Numbers: A/ _____ 1 R/ _____ 2
Mailing Address: _____ _____ _____	(Index Number continues to be used for ASHI; Retiree Number is used for Pension) For ASHI records, please provide Index (Payroll) Number: _____
Contact/Home Telephone No.: Email address:	

Requested Effective Date of Return to ASHI Coverage: \_\_\_\_\_

Please select plan:

Medical Plan:     Empire Blue Cross PPO     HIP (only available if already enrolled in HIP)  
                           Aetna PPO                                     UN WWP (The UN Worldwide Plan, administered by Cigna)

Dental Plan:     Please only select if you previously participated in Cigna Dental PPO (Please note that UN WWP includes dental coverage)

**List below spouse and/or children to be included in coverage**  
(Please Note: Only list participants who participated in your initial ASHI prior to your return to service.)

Last Name:	First Name:	Relationship:	Date of Birth: (DD/MM/YY)	Sex: (Male, Female, Other)

1. I hereby authorize the United Nations Joint Staff Pension Fund to deduct from my monthly pension benefit, and to remit directly to the United Nations, the premium contribution for my After Service Health Insurance (ASHI) Coverage.

2. I also authorize the United Nations Joint Staff Pension Fund 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.

3. I shall address all queries concerning health insurance premium contributions and deductions to the address below and not to the United Nations Joint Staff Pension Fund. I must provide written notice to the United Nations Health and Life Insurance Section in the event that I withdraw or change my health insurance coverage. The effective date of requested change will be the first of the month following change in applicant's status.

**After Service Health Insurance**  
Rm. FF-335  
304 E-45<sup>th</sup> Street, New York NY 10017

Fax: (917) 367-1670  
Email: [ashi@un.org](mailto:ashi@un.org)

Date (DD/MM/YY): \_\_\_\_\_ Signature: \_\_\_\_\_

<sup>1</sup> 6 digits in right hand corner of annual statement to forwarded to participant each year by UNJSPF  
<sup>2</sup> 5-digit number assigned by UNJSPF at time of separation (leave blank if not yet known)