



Application or Request for Change of Coverage for Active Staff Members

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

***Please Note: For ASHI purposes, please use the ASHI application form.**

Subscriber Part

Name (Last, First):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Date of Birth:
Address:	E-Mail:	UN Index No.:
Organization:		If non-UN, please specify subsidizing agency:
Duty Station:		Date of Entry on Duty:

Request	New Coverage to come into effect on		
	Change of Type of Coverage	FROM	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C. (** Please see below
		TO	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
	Additions: Eligible Family Members as indicated below		
	End of Coverage for	<input type="checkbox"/> Staff Member, to come into effect on	
	<input type="checkbox"/> Eligible Family Members as indicated below		
Change Name	FROM	TO	

() Type of Coverage Requested** (N.B. unmarried dependent child is insurable until the end of the year in which he/she turns 25. Child is considered dependent if not in full time employment.)

A: Staff Member only
 B: Staff Member and one eligible family member
 C: Staff Member and two or more eligible family members

Eligible Family Members (only those who are eligible for the Cigna Worldwide Plan (UN WWP))
Please indicate to which member the change applies.

Name	Sex	Relationship	Date of Birth	Marriage Date	Coverage Termination Date	US
<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>						<input type="checkbox"/>
<input type="checkbox"/>						<input type="checkbox"/>

Do you have dependents residing in the US? Yes, please tick box above No
Is your Spouse employed by the United Nations? Yes No

Are you or your eligible family members named above currently enrolled in any other Health Insurance Scheme? Yes No
If yes, please indicate which Scheme:

Under another UN Scheme, coverage will cease from the date you are enrolled in the Cigna Worldwide Plan (UN WWP).
Do you or your eligible family members named above have any other medical, hospital or dental insurance? Yes No

If yes, please indicate:

Employer's Name:	<i>Not applicable for staff members administered through the UNHQ HLIS in NY:</i>
Address:	
Insurance Company's Name and Address:	Personnel Adm. Section
Type of Coverage:	Received by: _____ Date: _____
<i>I hereby authorize the United Nations to make deductions from my salary to cover contributions to premiums at the rate appropriate to the coverage requested.</i>	Coverage to be effective
	Payroll Section
	Coded: Audited: Batch No.: Month:
Signature _____	Effective Date: MOTA: Currency Code:
Date Signed (DD/MM/YY) _____	