Application or Request for Change of Coverage under the UN Worldwide Plan for Active Staff Members

United Nations
Health & Life Insurance Section

UN Secretariat staff shall submit the completed form to: Health and Life Insurance Section (HLIS), Email: hlis@un.orgIf you are a staff member of another organization that is not included in Umoja (e.g. UNDP, UNICEF, UNFPA, UN WOMEN and UNOPS), you are required to submit this form to your respective organization

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

Subscriber Part

Name *(Last, First)*:	Sex: ☐ M ☐ F ☐ 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*: (please see below)	□ Eligibility Date (appointment date; date of marriage; birth or adoption of a child) □ First day of the month following the eligibility date
Change Type of Coverage** (please see below)	FROM □ A □ B □ C. TO □ A □ B □ C
End of Coverage for:	☐ Staff Member, to come into effect on: ☐ Eligible Family Members, as indicated below
Change Name	FROM TO

***Please note that insurance is not prorated. If you choose to begin coverage on your eligibility date and that date falls on the 29th of the month (for example), you will be charged for the entire month.**

****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 UN Worldwide Plan)

Please indicate to which member the change applies.

	Name	Sex	Relationship	Date of Birth	Marriage Date	Coverage Termination Date	US
☐							☐
☐							☐
☐							☐
☐							☐
☐							☐

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:
Address:

Insurance Company's Name and Address:
Type of Coverage:

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.

Signature _____ Date Signed (DD/MM/YY) _____

Not applicable for staff members administered through the UNHQ HLIS in NY:

Personnel Adm. Section
Received by: Date:
Coverage to be effective
Payroll Section
Coded: Audited: Batch No.: Month:

Effective Date: MOTA: Currency Code: