

APPLICATION FOR AFTER-SERVICE HEALTH INSURANCE

(This side to be completed by Applicant and sent to: United Nations Staff Mutual Insurance Society - Room 200, PALAIS DES NATIONS - CH-1211 GENEVA 10, SWITZERLAND)

I wish to obtain after-service coverage under the United Nations Health Insurance Scheme specified below for myself and for those eligible members of my family indicated on this form.

1. NAME OF APPLICANT: _____
(Family Name) (First) (Middle)

2. ADDRESS : _____

3. RELATIONSHIP to Former Staff Member

(Check relevant box): (a) SELF ☐ b) SPOUSE ☐ c) CHILD ☐

(d) OTHER (e.g. guardian) ☐ - Specify: _____

4. PERSONS TO BE INSURED (Complete for each person for whom Insurance is desired):

TO BE INSURED	Family Name	First	Middle	Sex		Date of Birth			Were persons listed insured at former staff member's separation from service?			List all UN (or Agency) plans under which former staff member was insured while still in service:	For Office Use Only (VERIFIED)
				M	F	Day	Mo.	Year	YES	NO	If "Yes" which plan?		
(I) Former Staff Member				<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
(II) Spouse or Surviving Spouse of Staff Member				<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
(III) Dependent Child of Former Staff Member	1.			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
	2.			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
	3.			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
	4.			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
	5.			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			
	6.			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>			

5. DATE FORMER STAFF MEMBER LEFT UNITED NATIONS SERVICE: Day _____ Month _____ Year _____

6. IF FORMER STAFF MEMBER HAS DIED, GIVE DATE OF DEATH: Day _____ Month _____ Year _____

7. DUTY STATION OF FORMER STAFF MEMBER AT SEPARATION DATE: _____

8. CATEGORY, GRADE AND STEP OF FORMER MEMBER AT SEPARATION DATE: _____

9. UNITED NATIONS HEALTH INSURANCE SCHEME UNDER WHICH AFTER-SERVICE COVERAGE IS DESIRED (Please check one box only)

- (a) UMS / AHS / Major Medical Plan ☐ (d) ECAFE-Bangkok GAHI Plan ☐
(b) HIP / AHS / Major Medical Plan ☐ (e) ECLA-Santiago Plan ☐
(c) United Nations GENEVA Plan ☐ (f) ECLA-Mexico City Plan ☐

I DECLARE THAT THE INFORMATION GIVEN ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF :

(Signature)

(Day) (Mo.) (Year)

FOR UNITED NATIONS OFFICE USE ONLY			
(Do not write in this space)			
Date Application Received by UNSMIS	Day	Mo.	Year
Pension Benefit Nos.			
Compensation Case Nos.			
INSURANCE COVERAGE NO.:			
UN Plan Code No.			
Participant No.			

FOR OFFICE USE ONLY (verified)	