

## Application for UNSMIS After-Service Health Insurance (ASHI) & Deduction of Premiums from the Pension Fund

### SECTION 1 – Applicant information (please complete in capital letters)

<b>NAME OF APPLICANT:</b>			<b>UN Index number:</b>	
<i>(Family name) (First name) (Middle name)</i>				
<b>MAILING ADDRESS:</b>			<b>UNJSPF Unique ID - UID (9 digits)</b>	
<i>(Please provide an updated mailing address where we can reach you if needed)</i>			<b>Insurance number:</b>	
<b>EMAIL ADDRESS (Personal):</b>			<b>PHONE NUMBER:</b>	
<b>Organization/Office:</b>			<b>Date of Separation/Retirement:</b>	
<b>Duty station:</b>		<i>(if former staff member is deceased, Date of Death)</i>		
<b>Please check appropriate box:</b> <input type="checkbox"/> Regular Retirement at 60, 62 or 65 <input type="checkbox"/> Early Retirement <input type="checkbox"/> Widow*/Widower*/Orphan <input type="checkbox"/> Deferred Pension <input type="checkbox"/> Disability <i>(must attach letter from Pension Fund)</i> <i>*Please note that you will lose this coverage upon re-marriage</i>			Number of years of <b>prior participation in another recognized UN medical insurance</b> under FTA or <b>indefinite</b> contract: <i>(please add number of years and name of UN medical insurance, e.g. 6 years in UN MIP)</i>	
<b>Relationship to former staff member:</b> <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER (e.g. guardian, please specify) .....				

### SECTION 2 – Dependent coverage

**IMPORTANT:** *If the covered spouse was a former staff member, the higher-pensioned retiree must carry the insurance in ASHI and submit this application form*

To be insured	Family name	First name	Middle name	Sex		Date of Birth	Insured at staff member's separation?	
				M	F		Day/Month/Year	NO
Spouse of Former Staff Member				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Dependent Child or SPP 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"/>

*Please complete page 2 as well.*

Continued

To be insured	Family name	First name	Middle name	Sex		Date of Birth Day/Month/Year	Insured at staff member's separation?	
				M	F		NO	YES
Dependent Child or SPP of Former Staff Member	6.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	7.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	8.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	9.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	10.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	11.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	12.			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If additional space is needed for dependents, please attach another form.

**SECTION 3**

**Authorization for deduction of monthly contributions for After-Service Health Insurance (ASHI) from United Nations Joint Staff Pension Fund (UNJSPF) pension benefits**

1. I hereby authorize the United Nations Joint Staff Pension Fund to deduct from my monthly pension benefit, and to remit directly to my former employing organization my premium contributions to the organization's health insurance scheme. I am aware of the fact that the amount of the deductions may be revised in the future, due to changes in the amount of premiums required and / or in the level of my pension benefit.
2. I also authorize the United Nations Joint Staff Pension Fund to provide from time to time, as required, information on the amount of my pension benefit to the office(s) of the organization responsible for administering the health insurance scheme.
3. I shall address all queries concerning health insurance premiums and deductions to the appropriate office(s) of the organization, and not the United Nations Joint Staff Pension fund. I have also noted that I must provide written notice to my former employing organization, at least six months in advance, if I should decide to withdraw or change my insurance coverage.

**I declare that the information given above is true and accurate to the best of my knowledge and belief.**

<p>.....</p> <p><u>Applicant's signature</u></p>	<p>.....</p> <p><u>Date (DD/MM/YYYY)</u></p>
--	--

Please return this form, duly completed through email to [unsmisaffiliations@un.org](mailto:unsmisaffiliations@un.org) .

## BANKING INSTRUCTIONS

<b>Last name:</b> (must match the name of the beneficiary bank account)		<b>First and middle name:</b> (must match the name of the beneficiary bank account)	
<b>Organization/Office:</b>	<b>Duty station</b> (City, Country):	<b>Phone number:</b>	<b>Index number:</b> (only for active staff members)
			<b>Insurance number:</b>
<b>Mailing address:</b> (must match the address of the beneficiary registered with this bank account)			
<b>E-mail address:</b>			
<b>Name of bank:</b>			
<b>Address of bank:</b>		<b>Country of bank:</b>	
<b>International bank account number (IBAN):</b> For all the Countries where the IBAN is mandatory in cross border payments			
<b>Account number:</b>		<b>Bank SWIFT code:</b>	
<b>Currency of bank account authorized:</b> <input type="checkbox"/> USD <input type="checkbox"/> CHF <input type="checkbox"/> EUR <input type="checkbox"/> GBP <input type="checkbox"/> AUD <input type="checkbox"/> CAD <input type="checkbox"/> DKK <input type="checkbox"/> HUF <input type="checkbox"/> JPY <input type="checkbox"/> MXN <input type="checkbox"/> NOK <input type="checkbox"/> NZD <input type="checkbox"/> PLN <input type="checkbox"/> SEK <input type="checkbox"/> SGD <input type="checkbox"/> THB <input type="checkbox"/> ZAR		<b>Corresponding bank:</b> <u>For all USD payments outside the USA*</u>	
<b>Additional information**:</b>			

*\* Kindly obtain the Corresponding Bank information from your bank to avoid possible higher bank fees charged by our default corresponding bank.*

\*\* If your Bank Account belongs to one of the following countries, kindly provide the additional information indicated:

- ⇒ AUSTRALIA and NEW ZEALAND: Please provide your 6-digit BSB Code, CANADA: Please provide your 8-digit Transit Number, MEXICO: Please provide your 18-digit CLABE, USA: Please provide your ABA Routing Number, UK: please provide your 6 digits Sort Code

<b>Signature:</b> (Primary member)	<b>Date:</b> (MM/DD/YYYY)
------------------------------------	---------------------------