OFFICE DES NATIONS UNIES À GENÈVE
ASSURANCE MUTUELLE CONTRE LA
MALADIE ET LES ACCIDENTS
DU PERSONNEL DES NATIONS UNIES

UNSMIS | UNITED NATIONS GENEVA

UNITED NATIONS OFFICE AT GENEVA
UNITED NATIONS STAFF MUTUAL
INSURANCE SOCIETY AGAINST
SICKNESS AND ACCIDENT

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

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

NAME OF APPLICANT: *(Family name)* *(First name)* *(Middle name)*			**UN Index number:**
MAILING ADDRESS: *(Please provide an updated mailing address where we can reach you if needed)*			**UNJSPF ID (Pension number):** **Insurance number:**
EMAIL ADDRESS (Personal)**:**		**PHONE NUMBER:**	
Organization/Office:	**Duty station:**	**Date of Separation:** *(if former staff member is deceased, Date of Death)*	

Please check appropriate box: ☐**Regular Retirement at 60, 62 or 65 (Article 28)** ☐**Early Retirement (Article 29)** ☐**Deferred Retirement Benefit (Article 30)*** ☐**Delaying election of benefit or payout (Article 32)*** **Please inform UNSMIS immediately of any changes in your election* ☐**Widow**/Widower**/Orphan** ***Please note that you cannot remain covered upon re-marriage* ☐**Disability** *(must attach letter from Pension Fund)*	**Date of Retirement:** *(as agreed with UNJSPF)* Number of years of **prior participation** in **another recognized UN medical insurance** (e.g. UN MIP) under FTA/indefinite contract:
Relationship to former staff member: ☐**SELF** ☐**SPOUSE** ☐**CHILD** ☐ **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	YES*	*Which plan?
Spouse of Former Staff Member					☐	☐		☐	☐	
Dependent Child or SPP of Former Staff Member	1.				☐	☐		☐	☐	
	2.				☐	☐		☐	☐	
	3.				☐	☐		☐	☐	
	4.				☐	☐		☐	☐	

Please complete page 2 as well.

Continued

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	YES*	*Which plan?
Dependent Child or SPP of Former Staff Member	5.				☐	☐		☐	☐	
	6.				☐	☐		☐	☐	
	7.				☐	☐		☐	☐	
	8.				☐	☐		☐	☐	
	9.				☐	☐		☐	☐	
	10.				☐	☐		☐	☐	
	11.				☐	☐		☐	☐	
	12.				☐	☐		☐	☐	

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.

……	……
Applicant's signature	Date (DD/MM/YYYY)

Please return this form, duly completed through email to unsmisaffiliations@un.org .

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BANKING INSTRUCTIONS

CLICK TO COPY DETAILS FROM ASHI FORM

Last name: (must match the name of the beneficiary bank account)		**First and middle name:** (must match the name of the beneficiary bank account)	
Organization/Office:	**Duty station** (City, Country):	**Phone number:**	**Index number:** (only for active staff members) **Insurance number:**
Mailing address: (must match the address of the beneficiary registered with this bank account)			
E-mail address:			

Name of bank:	
Address of bank:	**Country of bank:**
International bank account number (IBAN): For all the Countries where the IBAN is mandatory in cross border payments	
Account number:	**Bank SWIFT code:**
Currency of bank account authorized: ☐ **USD** ☐ **CHF** ☐ **EUR** ☐ **GBP** ☐ **AUD** ☐ **CAD** ☐ **DKK** ☐ **HUF** ☐ **JPY** ☐ **MXN** ☐ **NOK** ☐ **NZD** ☐ **PLN** ☐ **SEK** ☐ **SGD** ☐ **THB** ☐ **ZAR**	**Corresponding bank:** For all USD payments outside the USA*
Additional information:**	

** 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

Signature: (Primary member)	**Date**: (MM/DD/YYYY)