UNDP MEDICAL INSURANCE PLAN (MIP)
Application/Request for Change

DUTY STATION (COUNTRY/CITY): ____________________________

DATE OF ENROLMENT: _________________________

SUBSCRIBER INFORMATION:

☐ Active staff member ☐ Participating survivor (after service) ☐ Retiree (after service) ☐ Appendix D Beneficiary (after service)

☐ Abolition of post

☐ Cigna ID number (if any): ____________________

1. LAST NAME	2. FIRST NAME	3. DATE OF BIRTH (D/M/Y)	4. SEX	5. INDEX NO (if active) or Pension No (if retired)

6. GRADE/STEP	7. ORGANIZATION ☐ UNDP ☐ OTHER ___________

8. IF SPOUSE IS EMPLOYED BY UNDP, UN OR UN AGENCY INDICATE BELOW: ☐ SPOUSE IS NOT A UN STAFF MEMBER			
NAME:	INDEX NO:	ORGANIZATION:	GRADE/STEP:

9. PLEASE CHECK AS APPROPRIATE:

☐	NEW COVERAGE (not presently enrolled in MIP)
☐	RETURNED FROM SPECIAL LEAVE WITHOUT PAY DATE:
☐	ADD SPOUSE/CHILD(REN) (as listed in item 14 below)
☐	DELETE SPOUSE/CHILD(REN) (as listed in item 14 below)
☐	CHANGE OF NAME FROM: TO:
☐	TERMINATE COVERAGE FOR A FAMILY MEMBER

10. MARITAL STATUS:
☐ Married ☐ Separated ☐ Divorced ☐ Other

11. MARRIAGE DATE (D/MM/Y): / /

12. MEDICAL COVERAGE: DESIRED
☐ INDIVIDUAL
☐ STAFF MEMBER & SPOUSE
☐ STAFF MEMBER & ONE CHILD
☐ FAMILY (3 OR MORE PERSONS)

13. NO. PERSONS COVERED:

14. List below Spouse & Children to be enrolled/added/deleted LAST NAME	FIRST NAME	Sex M	F	Relationship	Date of Birth (D/M/Y)	Is Child Married	Is Child Employed Full-time	Add	Delete

NOTE: Unmarried dependent child, not in full time employment is insurable until the end of the calendar year in which he/she reaches the age of 25.

19. I HEREBY AUTHORIZE UNDP TO MAKE DEDUCTIONS FROM MY SALARY APPROPRIATE TO THE TYPE OF INSURANCE PLAN REQUESTED, AND I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS CORRECT.

DATE:

SIGNATURE: ______________________