UNDP SERVICE CONTRACT HOLDERS - GROUP MEDICAL INSURANCE PLAN

Application or request for change of coverage of dependents

Subscriber (UNDP Service Contract Holder)

Last name - First name

E-mail

Address

UNDP Service Contract ID n° Date of birth (d - m - y) Gender ☐ M ☐ F

Organisation ☐ UNDP ☐ Other:

Regional country office

Date of entry into duty

Request ☐ Additions: eligible family members as listed below

☐ End of coverage for eligible family members as listed below

Entry date of enrollment

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.

Eligible family members (only those who are eligible for the Cigna programme)

Last name - First name	Gender	Relationship (spouse, child)	Date of birth (d-m-y)	Child married?	Child full-time employed?	Add	Delete
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐
				☐ No ☐ Yes	☐ No ☐ Yes	☐	☐

I hereby authorize UNDP to make deductions from my salary to cover contributions to premiums at the rate appropriate to the coverage requested, and I certify that the information provided above is correct.

Date Signature

Please make copies for internal distribution.