Notification of a Service-Incurred Accident

A fully completed form facilitates its processing. Please return this form to:

PRIVATE AND CONFIDENTIAL

Cigna Healthcare: Please, send the form to the following e-mails (please, send to ALL e-mails indicated)
Clientservice1@cignahealthcare.com,
Unv.nationals@cignahealthcare.com,
Fax + 32 3 235 57 17, P.O. Box 69 - 2140 Antwerpen - Belgium

INJURED/AFFECTED UN VOLUNTEER

Family name of the plan member	
First name of the plan member	
Unified Volunteer Platform ID (UVP ID) of the plan member	
Date of birth (d-m-y)	
Gender	☐ M ☐ F
Email address	

DETAILS OF THE ACCIDENT

Did the accident occur during performance of the UN Volunteer assignment duties within official working hours for the assignment? *(Please refer to your organization's internal policy on work related accident for personnel)*	☐ No ☐ Yes
Date of accident (d-m-y)	
Place of accident (duty station, country)	
Detailed description of the circumstances of the accident and injuries/health consequences as a direct result of the accident	
Names and contacts of witnesses (if possible)	

I understand that the issuance of false certification related thereto is an offence punishable by Law. I hereby confirm that I have read and fully understood Cigna Healthcare's Data Protection Notice(https://www.cignahealthbenefits.com/en/privacy). If I provide Cigna Healthcare with personal information relating to others, I will make them aware of Cigna Healthcare's Data Protection Notice.

Date of submission	
UN Volunteer's Full Name and Signature	

I certify that the above information, provided by the UN Volunteer, is correct and compliant with Host Entity's policies and/or procedures for definition of a work-related accident. I confirm that I am an authorized Host Entity official to sign this form.

Host Entity's Name	
Full Name of authorized UN official	
Title of authorized UN official	
Signature of authorized UN official	