University of Wisconsin

Dependent Insurance Enrollment Form 2019-2020

INSTRUCTIONS: Please complete the enrollment form below, save and then send as an e-mail attachment to: enrollments@mycisi.com. Call (203) 399-5509 or e-mail enrollments@mycisi.com with any enrollment questions. **All fields** on this form must be completed/verified before we can process your enrollment.

Insurance may start no earlier than two days after the receipt of this completed enrollment form. Please allow two weeks for processing/receipt of insurance materials via e-mail.

PRIMARY INSURED'S INFORMATION (The "Primary Insured" is the University of Wisconsin education abroad participant or faculty/staff member abroad on University business with whom the dependent will be traveling)**:**

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________ Country of Destination: ______________________

Please indicate if you are faculty/staff or a student: ______________________

Coverage Start Date: ______________ Coverage End Date: ______________

U.S. Mailing Address: ______________________________________

City: ______________________ State: ________ Zip: ________

Phone number(s) to reach the Primary Insured for any questions on this form: ______________

Email address where materials should be sent: ______________________

DEPENDENT INFORMATION:

Please fill-in Type of Dependent Insurance needed (Spouse and/or Child & Rate): ______________________

Dependent Rates *(program length)*	One Week Rate* (1-8 days)	Two Week Rate (9-15 days)	Three Week Rate (16-22 days)	Monthly Rate (for >22 days or multiple months)
Cost per Dependent**	$13.00	$24.00	$37.00	$47.00

*There is a minimum charge equivalent to 7 days **Dependent means Spouse or Child

Please indicate the names (Last, First) of the Dependents to be insured, their date of birth, and their gender:

Spouse ______________________ Date of birth ______________ ☐ Female ☐ Male

Child ______________________ Date of birth ______________ ☐ Female ☐ Male

Child ______________________ Date of birth ______________ ☐ Female ☐ Male

Child ______________________ Date of birth ______________ ☐ Female ☐ Male

Child ______________________ Date of birth ______________ ☐ Female ☐ Male

Please start Dependent Insurance on ______________ and continue it until ______________

Dependent dates cannot exceed the Primary Insured's dates.

PAYMENT INFORMATION: Please provide your information below or call **203-399-5509** to provide the following credit card information over the phone.

☐ Visa ☐ Mastercard ☐ Amex Card Number: ______________________________ Expiration Date: __________

Cardholder's name (please print):____

Billing Address:____

street address apt/unit #

City:______________________________ State: ____________ Zip Code:______________

I have read/understand the terms/conditions of the policy and authorize payment for the above enrollment.

Signature:____Date:______________________

Please allow two weeks for material processing. All insurance materials are sent to the e-mail address provided above. Please contact CISI if you have any questions about this form or the policy.

Policy # 19 STB009987906