



University of Utah
Dependent Enrollment Form for Insurance



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 Utah 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: _____ UTAH Program Name: _____
 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: _____
 Destination Country & City: _____

DEPENDENT INFORMATION:

Please fill-in Type of Dependent Insurance Needed: _____

<u>Dependent Type</u>	<u>1-Week Rate</u>	<u>2-Week Rate</u>	<u>3-Week Rate</u>	<u>Monthly Rate</u>
Spouse	\$13.80	\$27.60	\$41.40	\$53.05
Child	\$15.80	\$31.60	\$47.40	\$60.90

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

Spouse _____	Date of birth _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child _____	Date of birth _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child _____	Date of birth _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child _____	Date of birth _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child _____	Date of birth _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male

Please start Dependent Insurance on _____ and continue it until _____

Dependent dates cannot exceed the Primary Insured's dates.

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

Visa Master Card Card Number: _____ Exp. Date: _____
 Cardholder's Name: _____
 Billing Address: _____
 City: _____ State: _____ Zip: _____

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

Printed or Typed Name: _____ Date: _____

Signature: _____

*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.*