

University of Wisconsin - SPAIN (requiring a visa)

Dependent Enrollment Form for Insurance 2023-2024

INSTRUCTIONS:

- Complete form below, save and send as an e-mail attachment to: enrollments@mycisi.com.
- All fields on this enrollment form must be completed before we can process your enrollment.
- You must be enrolled first before we can enroll your dependents.
- Insurance may start no earlier than two days after the receipt of this completed enrollment form.
- Please allow 5 business days for processing/receipt of insurance materials via e-mail. If you are leaving within 5 business days, please
 put in the subject line "EXPEDITE" when you submit the form and/or call 203-399-5509 to request for it to be expedited.

The "Primary Insured" is the University student or faculty/staff member abroad on university related business/program the dependent(s) will be traveling with: First Name:	STEP 1: PRIMARY INSURED	'S INFORMATION					
First Name: Last Name: Date of Birth: Department: Coverage End Date: U.S. Mailing Address: City: State: Zip: State: Zip: Dependent of any questions on this form: Coverage Start Date: Coverage Start Date:		e University student or	faculty/staff member	r abroad on universi	ty related business/progr	am the depe	endent(s)
Department: Coverage Start Date: U.S. Mailing Address: City: Phone number(s) to reach the Primary Insured for any questions on this form: Email address where materials should be sent: Country(ins) & City(ies) of Destination: Purpose of Travel: STEP 2: DEPENDENT INFORMATION Indicate type of dependent insurance needed: Dependent Rates 1-Week Rate 2-Week Rate 3-Week Rate (Program length) 1(1-7 days) 8-14-58 \$29.16 \$43.73 \$58.31 *Dependent* \$14-58 \$29.16 \$43.73 \$58.31 *Dependent means Spouse or Child **Monthly** **Per Dependent* \$14-58 \$29.16 \$43.73 \$58.31 **Dependent means (spouse or Child **Monthly Rate applies for any trips 22 days or longer Please provide the name(s) of the Dependent(s) to be insured, birthdate, and gender: DEPENDENT TYPE FIRST NAME BIRTHDATE GENDER **Dependent* Spouse:	-						
Coverage Start Date:							<u></u>
U.S. Mailing Address: City: State: Zip:	'						
City: State: Zip:			Cove	rage End Date:			<u></u>
Phone number(s) to reach the Primary Insured for any questions on this form: Email address where materials should be sent: Country(les) & City(les) of Destination: Purpose of Travel: STEP 2: DEPENDENT INFORMATION Indicate type of dependent insurance needed:	U.S. Mailing Address:						
Email address where materials should be sent: Country(ies) & City(ies) of Destination: Purpose of Travel: STEP 2: DEPENDENT INFORMATION Indicate type of dependent insurance needed: Spouse Child(ren) Spouse & Child(ren) Dependent Rates 1. Week Rate (Program length) (1-7 days) (8-14 days) (15-21 days) (22 days or longer) Per Dependent 514.58 529.16 543.73 \$558.31 *Dependent means Spouse or Child **Monthly Rate applies for any trips 22 days or longer Please provide the name(s) of the Dependent(s) to be insured, birthdate, and gender: DEPENDENT TYPE FIRST NAME LAST NAME BIRTHDATE GENDER Spouse: / / / Female Male Child: / / / Female Male Start Dependent(s) Insurance on and continue it until Dependent dates cannot exceed the Primary Insured's dates. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. STEP 3: PAYMENT INFORMATION Provide informa	· · · · · · · · · · · · · · · · · · ·				Zip:		
Country(ies) & City(ies) of Destination: Purpose of Travel: STEP 2: DEPENDENT INFORMATION Indicate type of dependent insurance needed:			or any questions on th	is form:			
Purpose of Travel: STEP 2: DEPENDENT INFORMATION Indicate type of dependent insurance needed:	Email address where mate	erials should be sent:					
Indicate type of dependent insurance needed:		Destination:					
Dependent Rates 1-Week Rate (1-7 days) (8-14 days) (15-21 days) (22 days or longer) Per Dependent** \$14.58 \$29.16 \$43.73 \$558.31 *Dependent means Spouse or Child **Monthly Rate applies for any trips 22 days or longer Per Dependent means Spouse or Child **Monthly Rate applies for any trips 22 days or longer Please provide the name(s) of the Dependent(s) to be insured, birthdate, and gender: Dependent Type FIRST NAME LAST NAME BIRTHDATE GENDER Spouse:	Purpose of Travel:						
Dependent Rates 1-Week Rate (1-7 days) (8-14 days) (15-21 days) (22 days or longer)	STEP 2: DEPENDENT INFOR	MATION					
Per Dependent* \$14.58 \$29.16 \$43.73 \$58.31 **Dependent means Spouse or Child ***Monthly Rate applies for any trips 22 days or longer Please provide the name(s) of the Dependent(s) to be insured, birthdate, and genders DEPENDENT TYPE FIRST NAME LAST NAME BIRTHDATE GENDER Spouse:	Indicate type of dependent	insurance needed: [Spouse Child	(ren) Spouse &	Child(ren)		
Per Dependent* \$14.58 \$29.16 \$43.73 \$58.31 **Dependent means Spouse or Child **Monthly Rate applies for any trips 22 days or longer Please provide the name(s) of the Dependent(s) to be insured, birthdate, and gender: DEPENDENT TYPE FIRST NAME LAST NAME BIRTHDATE GENDER Spouse:	Dependent Rates	1-Week Rate	2-Week Rate	3-Week Rate	Monthly**		
**Dependent means Spouse or Child **Monthly Rate applies for any trips 22 days or longer Please provide the name(s) of the Dependent(s) to be insured, birthdate, and gender: DEPENDENT TYPE FIRST NAME LAST NAME BIRTHDATE GENDER	(Program length)	(1-7 days)	(8-14 days)	(15-21 days)	(22 days or longer)		
Please provide the name(s) of the Dependent(s) to be insured, birthdate, and gender: DEPENDENT TYPE FIRST NAME LAST NAME BIRTHDATE GENDER	Per Dependent*	\$14.58	\$29.16	\$43.73	\$58.31		
Spouse:	*Dependent means Spous	e or Child **Monthly	Rate applies for any	trips 22 days or long	er		
Spouse:	Please provide the nam	e(s) of the Depender	nt(s) to be insured, I	oirthdate, and gen	der:		
Child:	DEPENDENT TYPE	FIRST NAME	<u>LAST</u>	<u>NAME</u>	<u>BIRTHDATE</u>	<u>GENI</u>	<u>DER</u>
Child:	Spouse:				/	Female	Male
Child:	Child:				//	Female	Male
Child:	Child:		_		/	Female	Male
Child:	Child:				/	Female	Male
Child:	Child:				//	Female	Male
Start Dependent(s) Insurance on and continue it until	Child:				//	Female	Male
Dependent dates cannot exceed the Primary Insured's dates. STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. Visa	Child:				//	Female	Male
STEP 3: PAYMENT INFORMATION Provide information below or call 203-399-5509 to provide the following credit card information over the phone. Visa	Start Dependent(s) Insurance on and continue it until						
Provide information below or call 203-399-5509 to provide the following credit card information over the phone. Visa		Dependent date	es <u>cannot exceed</u> the	Primary Insured's da	tes.		
Provide information below or call 203-399-5509 to provide the following credit card information over the phone. Visa	STEP 3: PAYMENT INFORM	ATION					
Visa Master Card Amex 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:			provide the following	g credit card informa	ation over the phone.		
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:					·		
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:		rd Amex Ca	ard Number:		Exp. Date:		
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:	-						
I have read/understand the terms/conditions of the policy and authorize payment for the above enrollment. Printed or Typed Name: Date:				C+	tato: 7in:		
Printed or Typed Name: Date:			b a malian and anoth ani				
" — — — — — — — — — — — — — — — — — — —		e terms/conditions of t	ne policy and authoriz	ze payment for the a			
ANHALIJE	Printed or Typed Name: Signature:				Date:		

Please allow 5 business days for material processing. Once processed, you will receive an email containing your dependent(s) insurance documents along with a receipt showing proof of payment. All insurance materials are sent to the e-mail address provided above.

Questions? E-mail enrollments@mycisi.com or Call (203) 399-5509.