CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

University of Wisconsin - STUDYAWAY

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/verified 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 submit the form and call 203-399-5509 to request for it to be expedited.*

STEP 1: PRIMARY INSURED'S INFORMATION

The "Primary Insured" is either 1) the university student or faculty/staff member on a Study Away program; or 2) the university international student or faculty/staff on an educational program or conducting research in their Home Country, the dependent(s) will be traveling with:

First Name: _____ Last Name: _____

Date of Birth: _____ Department: _____

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: _____

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 *(Program length)*	**1-Week Rate** (1-7 days)	**2-Week Rate** (8-14 days)	**3-Week Rate** (15-21 days)	**Monthly**** (22 days or longer)
Per Dependent*	$15.65	$31.31	$46.96	$62.61

**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
Child:	_____	_____	____/____/____	Female Male
Child:	_____	_____	____/____/____	Female Male
Child:	_____	_____	____/____/____	Female Male
Child:	_____	_____	____/____/____	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.

☐ 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: _____

Signature: _____

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.