

Iowa Regents Universities
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 Iowa Regents Universities education abroad student or faculty/staff member abroad on University related business/program the dependent will be traveling with):

First Name: _____ Last Name: _____
 Date of Birth: _____ Program: _____
 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 of Destination: _____

DEPENDENT INFORMATION:

Please indicate type of dependent insurance needed: Spouse Child(ren) Spouse & Child(ren)

<u>Dependent Type*</u>	<u>Up to 7 Days Rate**</u>	<u>Daily After 1 Week Rate</u>
Spouse/Child of Student	\$9.03	\$1.29
Spouse/Child of Faculty/Staff	\$8.19	\$1.17

*Rates are Per Dependent **There is a minimum charge equivalent to 7 days

Please indicate the name(s) of the Dependent(s) to be insured, birthdate, and gender:

<u>DEPENDENT TYPE</u>	<u>FIRST NAME</u>	<u>LAST NAME</u>	<u>BIRTHDATE</u>	<u>GENDER</u>
Spouse:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male

Please start Dependent(s) 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 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 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.