CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

Iowa Board of Regents

Personal Deviation/Extension of Insurance Coverage

INSTRUCTIONS: Faculty/Staff members abroad through Iowa Board of Regents may extend their insurance coverage before and/or after the program dates reported by your University, up to 14 days. You may secure this additional coverage by phone, e-mail, or fax. If you have any questions, you may contact our Client Services Associate, Kathleen Connors, directly at 203-399-5509 or by asking for enrollment assistance at 800-303-8120.

SECURING ADDITIONAL COVERAGE BY EMAIL: Please complete the enrollment form below, save, and then send as an e-mail attachment to enrollments@mycisi.com.

SECURING ADDITIONAL COVERAGE BY FAX: Please complete the enrollment form below, print, and then fax to 203-399-5596.

Insured Person	Up to 7 Days	Daily After 1 Week*
Faculty	$22.40	$3.20
Per Dependent	$ 49.00	$7.00

***Maximum of 14 days**

INSURED FACULTY MEMBER INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____ /_____ /_____

Email Address: _____ Phone Number(s) where we can reach you: _____

Destination Country(ies): _____

Destination City(ies): _____

INSURED DEPENDENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____ /_____ /_____

First Name: _____ Last Name: _____ Date of Birth: _____ /_____ /_____

First Name: _____ Last Name: _____ Date of Birth: _____ /_____ /_____

First Name: _____ Last Name: _____ Date of Birth: _____ /_____ /_____

First Name: _____ Last Name: _____ Date of Birth: _____ /_____ /_____

COVERAGE DATES ENROLLED FOR SCHOOL RELATED PROGRAM/TRAVEL

Coverage Start Date:_____ Coverage End Date: _____

COVERAGE DATES NEEDED OUTSIDE OF SCHOOL RELATED PROGRAM/TRAVEL DATES

Coverage Start Date:_____ Coverage End Date: _____

PAYMENT INFORMATION: Please provide the following credit card information *or* call 203-399-5509 to provide payment 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:_____

Insurance materials will be sent to the e-mail address you have provided above.