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 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)

Dependent Type	1-Week Rate	2-Week Rate	3-Week Rate	Monthly Rate**
Spouse	$14.78	$29.56	$44.34	$56.84
Per Child	$16.93	$33.86	$50.79	$65.26

***Monthly Rate applies for any trips 22 days or longer*

Please indicate 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

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.