CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

John Cabot University

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 John Cabot University faculty/staff member abroad with whom the dependent(s) 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)

Insured Type	Monthly Rate
Per Dependent*	$165.00

**Dependent means Spouse or Child*

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.