CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

# Boston College – Study Abroad

## *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 Boston College 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) ☐ Partner

| Dependent Type* | 1-Week Rate | 2-Week Rate | 3-Week Rate | Monthly Rate** |
|---|---|---|---|---|
| Spouse/Partner/Child* | $12.54 | $25.08 | $37.62 | $47.91 |

**Rates are Per Dependent*
***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 |
| Partner: | _____ | _____ | ____/____/____ | ☐ 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.*