



**Quinnipiac University – Domestic Travel**  
**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](mailto:enrollments@mycisi.com). Call (203) 399-5509 or e-mail [enrollments@mycisi.com](mailto: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 Quinnipiac University student or faculty/staff member on University related business/program within the U.S. that 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: \_\_\_\_\_  
 Destination State: \_\_\_\_\_

**DEPENDENT INFORMATION:**

Please fill-in Type of Dependent Insurance Needed: \_\_\_\_\_

DEPENDENT TYPE	RATE
<b>Spouse (Age Rated):</b>	<b>Monthly</b>
<25	\$22.82
25-34	\$29.68
35-49	\$37.92
50-64	\$48.97
65+	\$61.35
<b>Child (Not Age Rated):</b>	<b>\$21.44</b>

Please indicate the names (**Last, First**) of the Dependents to be insured, their date of birth, and their gender:

Spouse	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male

Please start Dependent 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    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.*