



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](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 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)

<u>Dependent Type</u>	<u>1-Week Rate</u>	<u>2-Week Rate</u>	<u>3-Week Rate</u>	<u>Monthly Rate**</u>
Spouse	\$15.56	\$31.12	\$46.68	\$59.83
Per Child	\$17.82	\$35.64	\$53.46	\$68.69

*\*\*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:

<u>DEPENDENT TYPE</u>	<u>FIRST NAME</u>	<u>LAST NAME</u>	<u>BIRTHDATE</u>	<u>GENDER</u>
Spouse:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child:	_____	_____	____/____/____	<input type="checkbox"/> Female <input type="checkbox"/> 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.*