CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

VIRGINIA TECH BUSINESS

VTH-OTHER

Dependent Enrollment Form for Insurance

Enrollment Form for Dependents Traveling with Virginia Tech Employees on University-Supported Business
(Not to be used by Students or Employees Traveling on Study Abroad)

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 Virginia Tech employee abroad on school related business 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/Per Child*	$ 39.97	$79.94	$119.91	$152.96

**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
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 or provide your phone number where we can reach you for this information (____)_____.

☐ 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.