CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

VTH-OTHER

VIRGINIA TECH BUSINESS

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 Employees on University related business with whom the dependent will be traveling)**:**

First Name: _____ Last Name: _____
Date of Birth: _____ Program Name: _____
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 Country: _____

DEPENDENT INFORMATION:

Please fill-in Type of Dependent Insurance Needed: _____

Dependent Rate Types	**Rates***
Weekly up to 3 weeks	$32.00 per week
Monthly	$122.10

*There is a minimum charge equivalent to 7 days

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

Spouse _____ Date of birth _____ ☐ Female ☐ Male
Child _____ Date of birth _____ ☐ Female ☐ Male
Child _____ Date of birth _____ ☐ Female ☐ Male
Child _____ Date of birth _____ ☐ Female ☐ Male
Child _____ Date of birth _____ ☐ Female ☐ 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. If you do not want to provide your information below, please call **203-399-5509** or provide your phone number where we can reach you for this information (____)_____

☐ 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.