University of Minnesota - Dependent Insurance Enrollment Form

INSTRUCTIONS: Please complete the enrollment form below, save and then send as an e-mail attachment to: enrollments@culturalinsurance.com. You may also fax it to 203-399-5596. If faxing, send a notice of having faxed it to enrollments@culturalinsurance.com. Call (203) 399-5134 or e-mail enrollments@culturalinsurance.com with 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 U of M education abroad participant or faculty/staff member abroad on University business)**:**

First Name_____ Last Name_____
Date of Birth_____ U of M ID #_____
Coverage Start Date_____ Coverage End Date_____
US Mailing Address_____
City_____State_____ZIP_____
Phone Number(s) we may reach the U of M Primary Insured at for any questions of this form
_____
E-mail address where dependent materials should be sent_____

DEPENDENT INFORMATION: Please fill-in Type of Dependent Insurance Needed (Choices are: Spouse Only, Child Only or Family Only)_____

Dependent Type	**Weekly Rate**** (up to 21 days, # of weeks times the rate)	**Monthly Rate**** (22 days or more, # of months times the rate)
Spouse Only (includes domestic partner)	$15.65	$61.80
Child Only	$23.50	$92.90
Family Only *	$31.35	$123.90
* Family means any combination of spouse and child(ren) or children only.		

Please indicate the names (Last, First) 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 end it on _____.
Please note that your credit card will be charged the premium for the full term of coverage requested (we do not bill incrementally). Dependent dates can not exceed the Primary Insured's dates. One week is the smallest unit of premium.

PAYMENT INFORMATION: Please provide the following credit card information:

□ Visa □ Master Card Card Number _____ Exp Date _____
Cardholder's name (please print)_____
Billing Address_____
City_____State_____ZIP_____
I have read/understand the terms/conditions of the policy and authorize full payment for the above enrollment.

Signature_____Date_____

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.

**Rates shown above are for coverage starting on or after August 1, 2016 and before August 1, 2017. Policy # 16 STB009998600