CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

University of Minnesota

Dependent Enrollment Form for Insurance

INSTRUCTIONS: Please complete the enrollment form below, save and then send as an e-mail attachment to: enrollments@culturalinsurance.com. Call (203) 399-5509 or e-mail enrollments@culturalinsurance.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 Minnesota education abroad participant or faculty/staff member abroad on University business with whom the dependent will be traveling)**:**

First Name: _____ Last Name: _____
Date of Birth: _____ Destination Country: _____
Please indicate if you are faculty/staff or a student: _____
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: _____

DEPENDENT INFORMATION:

Please fill-in Type of Dependent Insurance Needed: _____

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 (included domestic partner)	$20.00	$79.75
Child Only	$30.00	$119.75
Family Only*	$40.00	$160.00
*Family means any combination of spouse and child(ren) or children only.		

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 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.