

**VIRGINIA TECH ACADEMIC**

**Dependent Enrollment Form for Insurance**

***Enrollment Form for Dependents Traveling with Students or Faculty and Staff Leading Students Abroad***

**INSTRUCTIONS:** Please complete the enrollment form below, save and then send as an e-mail attachment to 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 Virginia Tech education abroad student or faculty/staff member abroad on a school related 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)

Dependent Type	1-Week Rate	2-Week Rate	3-Week Rate	Monthly Rate**
Spouse/Per Child*	\$ 20.90	\$41.80	\$62.70	\$80.05

\*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:	_____	_____	____/____/____	<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 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.*