

**University System of Georgia**  
**Dependent Enrollment Form for Insurance**

**INSTRUCTIONS:** Please complete the enrollment form below, save and then send as an e-mail attachment 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 University System of Georgia education abroad student or faculty/staff member abroad on university related business/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)

<u>Insured Type</u>	<u>Daily Rate*</u>
Dependent	\$1.36

*\*Rates are Per Dependent*

Please indicate the name(s) of the Dependent(s) to be insured, birthdate, and gender:

<u>DEPENDENT TYPE</u>	<u>FIRST NAME</u>	<u>LAST NAME</u>	<u>BIRTHDATE</u>	<u>GENDER</u>
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
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.

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.*