CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

VTH

VIRGINIA TECH ACADEMIC

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: enrollments@mycisi.com or fax to 203-399-5226. Call (203) 399-5509 or e-mail enrollments@myisi.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 participant or faculty/staff member abroad on University business with whom the dependent will be traveling)**:**

First Name: _____ Last Name: _____
Date of Birth: _____ Destination: _____
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	**Rate***
Weekly up to three week	$20.00 per week
Monthly	$76.45

*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 can not exceed the Primary Insured's dates.

PAYMENT INFORMATION: Please provide the following credit card information:
If you do not want to provide your credit card information on this form please include a phone number we can reach you on to take this 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: _____