CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

Texas A&M University System

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. Call (203) 399-5509 or e-mail 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 Texas A&M University education abroad participant or faculty/staff member abroad on University program/business with whom the dependent will be traveling)**:**

First Name: _____ Last Name: _____

Date of Birth: _____ TAMU Program Name: _____

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: _____

Destination Country: _____

DEPENDENT INFORMATION:

Please fill-in Type of Dependent Insurance Needed: _____

Dependent Type	**Daily Rate** (*A minimum charge of 7 days applies to all daily rates.*)
Spouse	$3.43
Child	$3.97

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 the following credit card information or call 203-399-5509.

☐ 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.