

CISI HEALTH/MEDICAL INSURANCE ENROLLMENT FORM

Please print clearly:

Last Name

First Name

EMPL ID

Birthdate MM/DD/YYYY

Gender

JMU email address

Name of Study Abroad Program (if applicable)

Destination (optional)

Insurance Premiums by Month												
Number of months	1	2	3	4	5	6	7	8	9	10	11	12
Premium amount	\$39	\$78	\$117	\$156	\$195	\$234	\$273	\$312	\$351	\$390	\$429	\$468

Use table above for the amount of premium for the number of months you are enrolling. Partial months are not available.

Effective date

MM/DD/YYYY

Number of months

End date

MM/DD/YYYY

Total charge

\$

Enrollment verification: I understand that by submitting this enrollment form to the JMU Office of International Programs, I will be billed for insurance at the rate of \$39 per month of coverage on or before the effective date of coverage. Payment is due within 2 weeks of billing date. Failure to make payment for insurance charges may jeopardize your coverage. Fees are not refundable after effective date of coverage. Coverage and services are described in the Policy Terms and Conditions.

Signature

Date

Return completed form to:
JMU Office of International Programs, JMAC 6, Suite 22, MSC 5731, Harrisonburg, VA 22807

Office use only:

Date received: _____ Date enrolled: _____ Date of charge: _____ Date of payment: _____