CISI
CULTURAL INSURANCE SERVICES INTERNATIONAL

James Madison University – J1 Visa Holders

Primary with Dependent(s) Enrollment Form for Insurance

INSTRUCTIONS: Please complete the enrollment form below, save, then send an e-mail attachment to: enrollments@mycisi.com, **and copy** isss@jmu.edu. 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.

PRIMARY INSURED'S INFORMATION (The "Primary Insured" is the James Madison University J1 visa holder):

First Name: _____ Last Name: _____

Date of Birth: _____ Home Country: _____

Coverage Start Date: _____ Coverage End Date: _____

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: _____

Code	Dependent Type	Monthly Rate
PS	PARTICIPANT AND SPOUSE	$349.82
P1	PARTICIPANT AND CHILD	$281.09
C1	PARTICIPANT, SPOUSE AND 1 CHILD	$332.63
PC	PARTICIPANT AND CHILDREN	$366.60
PF	PARTICIPANT AND FAMILY (Spouse & more than 1 Child)	$400.59

Please indicate the names (Last Name, First Name) of the Dependents to be insured, their date of birth, and their gender:

DEPENDENT TYPE	FIRST NAME	LAST NAME	BIRTHDATE	GENDER
Spouse:	_____	_____	___/___/___	☐ Female ☐ Male
Child:	_____	_____	___/___/___	☐ Female ☐ Male
Child:	_____	_____	___/___/___	☐ Female ☐ Male
Child:	_____	_____	___/___/___	☐ Female ☐ Male
Child:	_____	_____	___/___/___	☐ Female ☐ Male
Child:	_____	_____	___/___/___	☐ Female ☐ Male

Please start Dependent 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 a week 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.