

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.

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: _____

<u>Code</u>	<u>Dependent Type</u>	<u>Monthly Rate</u>
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:

<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

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.