



**University of Virginia – Business/Faculty Travel**  
**Faculty and 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](mailto:enrollments@mycisi.com). Call (203) 399-5509 or e-mail [enrollments@mycisi.com](mailto: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 UVA business/faculty traveler):

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Program: \_\_\_\_\_  
 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: \_\_\_\_\_  
 Country of Destination: \_\_\_\_\_

**DEPENDENT INFORMATION:**

Please fill-in Type of Dependent Insurance Needed: \_\_\_\_\_

Type	Monthly Rate
Dependent (Spouse or Child)	\$105.65

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

Spouse	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Child	_____	Date of birth	_____	<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    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.*