



University of Wisconsin - Dependent Insurance Enrollment Form

INSTRUCTIONS: Please complete the enrollment form below, save and then send as an e-mail attachment to: enrollments@culturalinsurance.com. Call (203) 399-5134 or e-mail enrollments@culturalinsurance.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 UW education abroad participant or faculty/staff member abroad on University business):

First Name _____ Last Name _____
 Date of Birth _____ UW ID # _____
 Coverage Start Date _____ Coverage End Date _____
 US Mailing Address _____
 City _____ State _____ ZIP _____
 Phone Number(s) we may reach the UW Primary Insured at for any questions of this form _____

 E-mail address where dependent materials should be sent _____

DEPENDENT INFORMATION:

<u>Dependent Rates</u> <u>(program length):</u>	<u>One Week Rate</u> <u>(1-8 days)</u>	<u>Two Week Rate</u> <u>(9-15 days)</u>	<u>Three Week Rate</u> <u>(16-22 days)</u>	<u>Monthly Rate (for >22</u> <u>days or multiple months)</u>
Cost per Dependent	\$12.00	\$23.00	\$35.00	\$45.00

Please indicate the names (Last, First) 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 end it on _____.
Please note that your credit card will be charged the premium for the full term of coverage requested (we do not bill incrementally). Dependent dates can not exceed the Primary Insured’s dates. One week is the smallest unit of premium.

PAYMENT INFORMATION: Please provide the following credit card information:

Visa Master Card Card Number _____ Exp Date _____
 Cardholder’s name (please print) _____
 Billing Address _____
 City _____ State _____ ZIP _____
 I have read/understand the terms/conditions of the policy and authorize payment for the above enrollment.

Signature _____ Date _____

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.