



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>(1-7days)</u>	<u>Two Week Rate</u> <u>(8-14 days)</u>	<u>Three Week Rate</u> <u>(15-21 days)</u>	<u>Monthly Rate (for >21</u> <u>days or multiple months)</u>
Cost per Dependent	\$15.00	\$29.00	\$44.00	\$58.00

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 _____.
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.