

**Iowa Regents Universities – Education Abroad Participants  
Dependent Enrollment Form for Comprehensive Insurance**

**INSTRUCTIONS:** Please complete the enrollment form below, save and then send as an e-mail attachment to: [enrollments@culturalinsurance.com](mailto:enrollments@culturalinsurance.com). Call (203) 399-5134 or e-mail [enrollments@culturalinsurance.com](mailto: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 Iowa Regents education abroad participant or faculty/staff member abroad on University business with whom the dependent will be traveling):

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ IOWA Institution Name: -- SELECT ONE --  
 Please indicate if you are faculty/staff or a student: \_\_\_\_\_  
 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: \_\_\_\_\_

**DEPENDENT INFORMATION:**

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

<b>Dependent Type</b>	<b>Daily Rate*</b>
Child/Spouse of student	\$1.31
Child/Spouse of faculty/staff	\$1.19

\*There is a minimum charge equivalent to 7 days

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

Please start Dependent Insurance on \_\_\_\_\_ and continue it until \_\_\_\_\_  
*Dependent dates can not exceed the Primary Insured’s dates.*

**PAYMENT INFORMATION:** Please provide the following credit card information:

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.*