James Madison University – J1 Visa Holders

Primary with Dependent(s) Enrollment Form for Insurance

INSTRUCTIONS: Please complete the enrollment form below, save, then send an e-mail attachment to: enrollments@mycisi.com, **and copy** isss@jmu.edu. 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: ____________________

Code	Dependent Type	Monthly Rate
PS	PARTICIPANT AND SPOUSE	$312.63
P1	PARTICIPANT AND CHILD	$251.21
C1	PARTICIPANT, SPOUSE AND 1 CHILD	$297.27
PC	PARTICIPANT AND CHILDREN	$327.63
PF	PARTICIPANT AND FAMILY (Spouse & more than 1 Child)	$358.00

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

DEPENDENT TYPE	FIRST NAME	LAST NAME	BIRTHDATE	GENDER
Spouse:	______________	______________	_____/_____/_____	☐ Female ☐ Male
Child:	______________	______________	_____/_____/_____	☐ Female ☐ Male
Child:	______________	______________	_____/_____/_____	☐ Female ☐ Male
Child:	______________	______________	_____/_____/_____	☐ Female ☐ Male
Child:	______________	______________	_____/_____/_____	☐ Female ☐ Male
Child:	______________	______________	_____/_____/_____	☐ Female ☐ 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.