



University of New Mexico
Dependent Enrollment Form for Insurance

INSTRUCTIONS: Please complete the enrollment form below, save and then send as an e-mail attachment to: enrollments@culturalinsurance.com. Call (203) 399-5509 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 a week for processing/receipt of insurance materials via e-mail.

PRIMARY INSURED'S INFORMATION (The "Primary Insured" is the University of New Mexico 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: _____ Destination Country: _____
 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: _____

| | Weekly (minimum of 2 weeks) | Monthly Rate |
|--|------------------------------------|---------------------|
| Dependent (Child(ren)/Spouses) | \$24.75 | \$98.90 |

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 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 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.