



UVA Business Traveler

Personal Extension of Insurance Coverage

INSTRUCTIONS: Faculty/Staff members abroad on approved UVA Business Travel may extend their insurance coverage before and/or after the university-related travel dates reported by UVA. The personal extension cannot exceed 30 days. If the only reason you are traveling abroad is for personal travel/vacation, this coverage is not available.

How to secure coverage:

1. You must be enrolled for your approved business travel dates.
2. Complete the form below.
3. Submit to enrollments@mycisi.com as an attachment or fax to 203-399-5596.

Once enrolled, insurance materials and receipt will be sent to the email address provided in the 'INSURED FACULTY/STAFF MEMBER INFORMATION' section of this form.

QUESTIONS? Call 203-399-5509 or email enrollments@mycisi.com.

RATES:

Insured Type	1-Week Rate (1-7 days)	2-Week Rate (8-14 days)	3-Week Rate (15-21 days)	Monthly Rate (22 days or longer)
Faculty/Staff	\$16.05	\$32.10	\$48.15	\$65.10
Per Dependent	\$27.50	\$55.00	\$82.50	\$109.00

FACULTY/STAFF MEMBER INFORMATION:

First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____
 Email Address: _____ Phone Number(s) where we can reach you: _____

DEPENDENT INFORMATION (IF ACCOMPANYING):

First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ Gender: ____
 First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ Gender: ____
 First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ Gender: ____
 First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ Gender: ____
 First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ Gender: ____

COVERAGE DATES ENROLLED FOR UVA-RELATED TRAVEL:

Coverage Start Date: _____ Coverage End Date: _____

COVERAGE DATES NEEDED OUTSIDE OF THE UVA-RELATED TRAVEL DATES:**

If traveling BEFORE the UVA-Related Travel: Coverage Start Date: _____ Coverage End Date: _____

Destination Country(ies): _____

Destination City(ies): _____

If traveling AFTER the UVA-Related Travel: Coverage Start Date: _____ Coverage End Date: _____

Destination Country(ies): _____

Destination City(ies): _____

*****IMPORTANT, if traveling with a dependent(s): Dependent dates cannot exceed the insured faculty/staff member's dates.***

PAYMENT INFORMATION: Provide the following credit card information or call 203-399-5509 to provide payment information over the phone:

Visa Mastercard Amex Card Number: _____ Expiration Date: _____

Cardholder's name (please print): _____

Billing Address: _____ City: _____ State: _____ Zip Code: _____
street address apt/unit #

I have read/understand the terms/conditions of the policy and authorize payment for the above enrollment.

Signature: _____ Date: _____