INTERNATIONAL HEALTH INSURANCE WAIVER FORM

ACADEMIC YEAR: 2011-12 SEMESTER (CIRCLE ONE): FALL SPRING SUMMER

(This waiver form is for SUNY at Buffalo international students only.)

PLEASE SUBMIT TO: SUITE 223 STUDENT UNION , SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 / FAX: (716) 645-3465 / PDF E-MAIL: ASKSMI@BUFFALO.EDU

Please print clearly and carefully read the following stipulations:

1.) **Partial and/or incomplete waivers will not be processed** and the applicant may be subject to late fees from the Student Medical Insurance Office and/or the UB Bursars Office. Communication requesting further information will be directed to the e-mail address supplied by the applicant below.
2.) **All waivers must be accompanied with proof of enrollment.** (A photocopy of an insurance ID card or a letter from your employer/government stating effective dates of coverage—*all private insurance must be in effect by the first day of classes in order to waive the University Insurance policy*).
3.) Any student presenting a privately held insurance policy for waiver may be e-mailed at the address provided below and required to provide a Clarification of Benefits form in order to determine the comparability of the private policy to SUNY's requirements.
4.) **Submission Deadline for SPRING 2012 waivers: FEBRUARY 25, 2012**
   a. **Late Waiver Submission Deadline: MARCH 24, 2012**
   (All late waivers must be accompanied by a $50.00 processing fee payable to "Sub-Board I, Inc.")
   b. No waiver requests will be accepted or considered past March 24, 2012

APPLICANTS MUST COMPLETE ALL FIELDS:

_____ _ _____ _____ DATE OF BIRTH: _____/_____/_____
LAST NAME FIRST NAME MI Mo. Day Year

_____ _____ _____ _____
U.S. MAILING ADDRESS TOWN/CITY STATE /PROV ZIP CODE

(_____) _____ - _____ _____ _____ _____
U.S. TELEPHONE EMAIL ADDRESS UB DEPT OR PROGRAM HOME COUNTRY

___ ___ ___ ___ - ___ ___ ___ ___ _____
UB PERSON NUMBER VISA TYPE O MALE or O FEMALE

NAME OF COMPANY/AGENCY ISSUING YOUR POLICY:_____

HAVE YOU WAIVED UB'S INSURANCE IN A PREVIOUS YEAR WITH THIS SAME POLICY ? O YES or O NO

ARE YOU A STUDENT COVERED BY A SPONSORING AGENCY (FULBRIGHT, YOUR EMBASSY, ETC.) ? O YES _____ or O NO
SPECIFY

I UNDERSTAND THAT A WAIVER MAY ONLY BE PROCESSED IF MY PRIVATE INSURANCE IS COMPARABLE TO EVERY POLICY ITEM MANDATED BY THE STATE UNIVERSITY OF NEW YORK. I ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH 14 AUGUST 2012 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2012-2013 ACADEMIC YEAR. I ALSO FULLY AGREE TO HOLD HARMLESS THE STATE UNIVERSITY OF NEW YORK, THE UNIVERSITY AT BUFFALO AND SUB-BOARD I, INC., AND ALL AGENTS AND AGENCIES OF THE AFORESAID ORGANIZATIONS, FOR ANY MEDICAL EXPENSES I MAY INCUR DUE TO LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT MEDICAL INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AND/OR DENY ANY REQUEST FOR WAIVER AT THEIR DESCRETION. **I UNDERSTAND THAT IF I USE THE LAB OR PHARMACY IN MICHAEL HALL AND HAVE THE CHARGES BILLED TO THE INTERNATIONAL INSURANCE PLAN, I WILL BE CHARGED RETROACTIVELY FOR THE FULL MEDICAL INSURANCE PREMIUM WITHOUT POSSIBILITY OF WAIVER.**

_____ DATE: _____/_____/_____
APPLICANT'S SIGNATURE Mo. Day Year

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FOR OFFICE USE ONLY: DATE PROCESSED _____/_____/_____

O Accepted
O Deleted from roster
O Accepted with MEDEX
O Letter of notification
O Enrolled into Class 8 Date:_____
O Denied
O Letter of notification

OSA_____ HTH_____