SBI
Student Owned Services

STUDENT MEDICAL INSURANCE OFFICE
University at Buffalo • 223 Student Union, Buffalo, NY 14260
Tel: (716)645-3036 • Fax: (716)645-3465 • Web: www.healthinsurance.buffalo.edu

LATE WAIVER PETITION – FALL 2011

Student Name: _____

UB Person Number: _____

UB-IT E-mail Address: _____

The online waiver deadline for the mandatory UB insurance assessment was **October 4, 2011**. If you carry private health insurance that meets or exceeds the requirements for waiver of the mandatory UB-AETNA program, you may still be eligible for waiver of premium and participation. In order to continue with this process, please verify that your private insurance policy was effective on or before **September 1, 2011**—if it was not, you cannot be considered for waiver for the 2011-2012 academic year.

Step One: Print and complete this form.

Step Two: Send the attached verification form to your health insurance company. This form must be signed by a Representative at your insurance company with a telephone number provided for contact and verification purposes.

Step Three**:** Return to the Student Medical Insurance Office (address in header) *before November 8, 2011*:

1.) This form completed and signed below.
2.) The International waiver form and Comparability form completed by an insurance company representative.
3.) Late Waiver Processing Fee of $50.00 for each month that the waiver is late, exact cash, check or money order payable to "Sub-Board I, Inc"
4) Written explanation of circumstances for petition request.
5.) Signed HIPAA release for enrollment/benefit information.

—Student Acknowledgement and Certification—

I, the above named student, hereby petition for late waiver of the mandatory UB-AETNA policy. I agree to pay the appropriate late processing fee to "Sub-Board I, Inc" as a processing fee due to my waiver being submitted after the October 4, 2011 deadline. I agree to submit all paperwork requested above and realize that my coverage will be verified by the UB Student Medical Insurance Office (SMI) to determine my eligibility for waiver as per the health insurance requirements for attendance at UB. If my waiver cannot be granted, I may not be refunded the processing fee from SMI at 223 Student Union or Sub Board One, Inc. I understand and agree that all communication pursuant to this process will be e-mailed to my UB-IT e-mail address provided above. Furthermore, I am fully aware that this is an annual online process to be completed each academic year that I am registered as an undergraduate carrying 12+ credit hours or a graduate/professional student carrying 9+ credit hours.

Student Signature: _____ Date: _____ / _____ / _____

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 FALL 2011 waivers: OCTOBER 4, 2011**
   a. **Late Waiver Submission Deadline: NOVEMBER 8, 2011**
   (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 NOVEMBER 8, 2011

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 2011 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2011-2012 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_____

INSURANCE COMPANY
Please Return this Form ASAP
By Fax: 716-645-3465
By Mail: University at Buffalo Medical Insurance, Suite 223 Student Union, Buffalo, NY 14260
By E-mail PDF: AskSMI@buffalo.edu

CLARIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgment at the bottom of the form. All monetary units must be expressed both in the relevant foreign currency and in U.S. dollars at the current exchange rate.

Student Name: _____ _____ ___ UB Person #: _____
Last Name First Name MI

1. Effective dates of coverage _____ through _____

2. Total maximum benefit amount _____ $_____

3. Deductible amount _____ $_____

4. Accidental death benefit _____ $_____

5. Dismemberment benefit _____ $_____

6. Are pre-existing conditions covered? Yes ___ No ___

   Duration of possible waiting period? ___ Months

   *Has it been met? Yes ___ No ___

7. Is medical evacuation covered? Yes ___ No ___
   To what amount? _____ $_____

8. Is repatriation covered? Yes ___ No ___
   To what amount? _____ $_____

9. Maximum daily benefit for in-hospital room & board $_____

10. Are outpatient emotional and mental disorders covered? Yes ___ No ___
    To what amount? _____ $_____

11. Are inpatient emotional and mental disorders covered? Yes ___ No ___
    To what amount? _____ $_____

12. Is outpatient alcoholism and substance abuse covered? Yes ___ No ___
    To what amount? _____ $_____

13. Are prescription drugs covered? Yes ___ No ___ Limit$_____

14. Are x-rays and lab work covered? Yes ___ No ___ Limit$_____

15. Are ambulance charges and medical equipment rental expenses covered? Yes ___ No ___ Limit$_____

_____ _____ _____ ____ / ____ /____
Insurance Company's Name Representive Name(Please Print) Phone Number Date

I take full responsibility for the answers I have supplied above, and fully agree to hold harmless the University at Buffalo for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give permission for enrollment and benefit information to be released to the Student Medical Insurance Office at the University of Buffalo for the purpose of attempting an insurance waiver and to file for statistical use and use of the participant for medical reasons.

_____ ____ / ____ / _____
Policy Holder's Signature Date Policy Holder's Email Address

Sub-Board I, Inc.

AUTHORIZATION for HEALTH CARE / HEALTH INSURANCE ADVOCACY

Information about you and your health is personal and Sub-Board I, Inc. (SBI) is committed to protecting the privacy of such information. In addition, your personal health information (PHI) is, in many cases, protected from use and disclosure by both State and Federal law. As a result, SBI will not use your PHI to advocate on your behalf with respect to health care or health insurance matters unless you sign this form permitting SBI to use your PHI for this purpose. Please carefully read this form and the information set forth below before signing.

Patient Name: _____ UB Person Number _____-_____

Address: _____

_____

DOB: _____ Telephone #: _____(day) _____(eve)

I herby authorize representatives of SBI to release/request information related to my medical care for the specified date(s) or type(s) of service to the specified insurer(s) and/or provider(s):

Date(s) and/or Type(s) of Service:

☐ Name of Insurance Company _____

☐

☐ Verification of health insurance enrollment and general policy benefits: _____

Insurers:

☐ The specified health care insurers and/or HMOs: _____

Please specify individual insurer(s) and/or HMO(s)

By providing this authorization, I give permission for representatives of SBI to discuss the medical care that I received from the above named providers, during the time period listed, as well as the actual or requested payment for such care, with both the providers and insurers listed above. I understand that I can rescind this authorization at any time thereby affecting future (but not past) communications. If not earlier rescinded by me, this authorization shall expire on _____.

(specify expiration date)

_____ _____

Print Name of Patient (or Personal Representative[1]) Signature of Patient (or Personal Representative[1])

_____

Date

[1] As defined in 45 CRF §164.502(g)