

# ENROLLMENT FORM FOR STUDY ABROAD HEALTH INSURANCE

Academic Policy Year: 2015-2016 SEMESTER (circle one): FALL SPRING SUMMER

*PLEASE RETURN TO: SUITE 315 STUDENT UNION, SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260  
PH: (716) 645-3036 / FAX: (716) 645-3465 / PDF E-MAIL: ASKSMI@BUFFALO.EDU*

Destination of Domestic Student/Faculty Abroad: \_\_\_\_\_  
UB Faculty Advisor for Program Abroad: \_\_\_\_\_ Advisor E-mail: \_\_\_\_\_

\_\_\_\_\_  
LAST NAME FIRST NAME MI DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Mo. Day Year  
\_\_\_\_\_  
PREFERRED MAILING ADDRESS CITY STATE ZIP CODE  
(\_\_\_\_) \_\_\_\_\_  
PREFERRED TELEPHONE E-MAIL ADDRESS UB DEPT OR PROGRAM HOME COUNTRY  
\_\_\_\_\_  
UB PERSON NUMBER ☐ MALE or ☐ FEMALE

CURRENT EDUCATIONAL LEVEL: (CIRCLE ONE) UNDERGRAD GRADUATE PROFESSIONAL FACULTY/STAFF/RESEARCH

Insurance periods cover from the 15<sup>th</sup> of one month to the 14<sup>th</sup> of the next month. For example, if you want coverage from Feb. 1 to Mar. 10, you would have to pay for two whole months (enrolling 15<sup>th</sup> January through 14<sup>th</sup> March). There are no exceptions without prior approval of the insurance office.

**DATES OF COVERAGE :** FROM \_\_\_\_ / 15 / \_\_\_\_ TO \_\_\_\_ / 14 / \_\_\_\_

*Alternative Coverage Dates: FROM \_\_\_\_ / \_\_\_\_ / \_\_\_\_ TO \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Requires Prior Administrative Approval From SMI Office to Sponsoring Department—not optional to participant.)*

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/15 - 1/14/16		5/15/16 - 8/14/16	
8/15/15-8/14/16	<b>OR SPRING</b>	1/15/16 - 8/14/16	<b>OR 3 MONTHS</b>	X/15/XX - X/14/XX
	1/15/16 - 6/14/16		X/15/XX - X/14/XX	
\$518.00	\$215.75	\$302.20	\$129.50	\$43.25

Please indicate payment (circle one): **UB STUDENTS MUST HAVE THEIR STUDENT ACCOUNT BILLED.**

Cash, Check or Money Order Enclosed <b>Make check payable to SUNY at Buffalo</b>	Please Bill My Student Account (double check your person number above)	Please Invoice My Department (prior approval from insurance office required)
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I wish to enroll on the SUNY International Health Insurance program for the above period. I understand this includes payment of the insurance premium and a non-refundable administrative fee. I understand that by signing this enrollment form I decline the option of waiving the international insurance plan for my SUNY sponsored International Exchange or Study Abroad.

\_\_\_\_\_  
APPLICANT'S SIGNATURE TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Mo. Day Year

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FOR OFFICE USE ONLY:

Check number: \_\_\_\_\_ Receipt number: \_\_\_\_\_ Payment amount \$: \_\_\_\_\_ Received by: \_\_\_\_\_

Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Class: 5

OSA: \_\_\_\_\_ HTH: \_\_\_\_\_ Previously GSEU / RF? YES NO

Roster Update: \_\_\_\_\_