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