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 2010 – (MEDICAL/DENTAL/NURSING)

Student Name: _____

UB Person Number: _____

UB-IT E-mail Address: _____

The online waiver deadline for the mandatory UB insurance assessment was **October 5th, 2010**. 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 1st, 2010—if it was not, you cannot be considered for waiver for the 2010-2011 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 2, 2010*:

1.) This form completed and signed below.
2.) The attached verification form completed and certified by an insurance company representative.
3.) Late Waiver Processing Fee of $50.00 exact cash, check or money order payable to "Sub-Board I, Inc.".
4.) 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 $50.00 to "Sub-Board I, Inc" as a processing fee due to my waiver being submitted after the October 5th, 2010 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 retrieve my processing fee from SMI at 223 Student Union. 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: _____ / _____ / _____

University at Buffalo
Medical, Dental, & Nursing Student Plan
Insurance Verification Form

Copies of Insurance policies are not acceptable.

The University at Buffalo requires all full-time students to maintain health insurance providing coverage for in-patient and out-patient, mental health, as well as catastrophic illness and injury. The student may satisfy the insurance requirements through private or employer sponsored plans that meet certain minimum criteria or through enrollment in a group insurance plan.

Section I (To be completed by Student)

Student Name: Last: _____ First: _____ Phone Number: _____

UB Person #: _____ Email Address : _____

Student Address: _____

City: _____ State: _____ Zip: _____

Section II (MUST be completed by an Insurance Company Representative)

Name of Insurance Company: _____

Member Name: _____

Member ID Number: _____Country:_____

Group Number: _____ Policy Number _____

Effective Date: _____

Expiration Date: _____

I hereby attest that this plan meets the following standards:

Yes / No	The subscriber's plan offers coverage of at least $1 million per condition.
Yes / No	The subscriber's plan covers Inpatient and Outpatient medical care within 25 miles of the University at Buffalo campus area. *Emergency Only coverage does not meet this requirement.*
Yes / No	The subscriber's plan covers Inpatient and Outpatient mental health care within 25 miles of the University at Buffalo campus area. *Emergency Only coverage does not meet this requirement.*
Yes / No	The subscriber's plan provides coverage for pre-existing conditions or has met the pre-existing conditions waiting period.
Yes / No	The subscriber's plan provides prescription drug coverage (either as part of this medical plan or as a separate prescription plan).
Yes / No	The subscriber's plan is currently active and has been/will be effective from 9-1-2010 through 5-1-2011. (Please check here ____ if this plan requires periodic recertification for continuation.)

_____

REQUIRED: Insurance Carrier Signature

_____

Insurance Carrier Phone Number

Please Return To:
UB Student Medical Insurance Office
Suite 223 Student Union
Buffalo, NY 14260
Fax: (716) 645-3465
E-mail: asksmi@buffalo.edu

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: _____ Social Security #: _____-____-_____

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:

- ☐ Health care for or on the following date(s) only: _____
- ☐ All health care provided
- ☐ Verification of health insurance enrollment and general policy benefits: _____

Providers:

- ☐ All health care providers (including physicians and hospitals)
- ☐ Health care from the following provider(s) only: _____
  Please specify individual provider(s)

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)