

INTERNATIONAL HEALTH INSURANCE WAIVER FORM

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

PLEASE SUBMIT TO: 1CAPEN, SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 / FAX: (716) 645-3948 / 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.) Any student presenting a privately held insurance policy for waiver must provide an insurance ID card, and Clarification of Benefits form, completed by the insurance company or Human Resources department, in order to determine the comparability of the private policy to SUNY's requirements.
- 3.) Submission Deadline for SPRING 2018 waivers: MARCH 14, 2018
 - a. Late Waiver Submission Deadline: APRIL 18, 2018 (\$50 Late-Fee)

APPLICANTS MUST COMPLETE ALL FIELDS:

_____ LAST NAME		_____ FIRST NAME		_____ MI	DATE OF BIRTH: ____/____/____ 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		<input type="radio"/> MALE or <input type="radio"/> FEMALE			

NAME OF COMPANY/AGENCY ISSUING YOUR POLICY: _____

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

ARE YOU A STUDENT COVERED BY A SPONSORING AGENCY (FULBRIGHT, YOUR EMBASSY, ETC.) ? ☐ YES _____ or ☐ 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 2018 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2018-2019 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 DISCRETION. I UNDERSTAND THAT IF I USE THE 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.

APPLICANT'S SIGNATURE

DATE: ____/____/____
Mo. Day Year

FOR OFFICE USE ONLY:

DATE PROCESSED ____/____/____

☐ Accepted

☐ Accepted with MedEvac

☐ Denied

☐ Letter of notification

☐ Letter of notification

OSA _____

HTH _____

INSURANCE COMPANY/HR Representative:

Please return this form ASAP

By Fax: 716-645-3465

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 acknowledgement at the bottom of the form. All monetary units must be expressed in U.S. dollars.

Student Name: _____ Person number: _____

Insurance Company Name: _____ Last Name First Name MI Policy Number: _____

- | | | | |
|--|-----------------------|---------|-----------------------|
| 1. Effective dates of coverage | _____ / _____ / _____ | Through | _____ / _____ / _____ |
| 2. Total maximum benefit amount | _____ | | \$ _____ |
| 3. Are pre-existing conditions covered? | _____ | YES | NO |
| 4. Does plan directly pay benefits to providers in the USA? | _____ | YES | NO |
| 5. Is medical evacuation covered? | _____ | YES | NO |
| To what amount? | _____ | | \$ _____ |
| 6. Is repatriation covered? | _____ | YES | NO |
| To what amount? | _____ | | \$ _____ |
| 7. Maximum daily benefit for in-hospital room & board | _____ | | \$ _____ |
| 8. Are outpatient emotional and mental disorders covered? | _____ | YES | NO |
| To what amount? | _____ | | \$ _____ |
| 9. Are inpatient emotional and mental disorders covered? | _____ | YES | NO |
| To what amount? | _____ | | \$ _____ |
| 10. Is outpatient alcoholism and substance abuse covered? | _____ | YES | NO |
| To what amount? | _____ | | \$ _____ |
| 11. Are prescription drugs covered? | _____ | YES | NO |
| 12. Are x-rays and lab work covered? | _____ | YES | NO |
| 13. Are ambulance charges and medical equipment rental expenses covered? | _____ | YES | NO |

Insurance/HR Representative Name _____ Insurance/HR Representative Signature _____ Phone _____ Date _____ / _____ / _____

I affirm all of the supplied information above is truthful. I take full responsibility for the answers I have supplied above, and fully agree to hold harmless the University at Buffalo/Sub Board I, Inc. 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 SBI Student medical Insurance Office at the University at 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 Signature _____ Date _____ / _____ / _____ Policy Holder's Email Address _____