

ENROLLMENT FORM FOR STUDY ABROAD HEALTH INSURANCE

SPRING 2014

*PLEASE RETURN 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*

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

_____	_____	_____	DATE OF BIRTH: ____ / ____ / ____
LAST NAME	FIRST NAME	MI	Mo. Day Year
_____		_____	_____
PREFERRED MAILING ADDRESS		CITY	STATE ZIP CODE
(____) _____	_____	_____	_____
PREFERRED TELEPHONE	E-MAIL ADDRESS	UB DEPT OR PROGRAM	HOME COUNTRY

UB PERSON NUMBER	<input type="radio"/> MALE or <input type="radio"/> FEMALE		

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

Insurance periods cover from the 15th of one month to the 14th 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 15th January through 14th March). There are no exceptions without prior approval of the insurance office.

DATES OF COVERAGE : FROM ____ / 15 / ____ TO ____ / 14 / ____ <i>Alternative Coverage Dates: FROM ____ / ____ / ____ TO ____ / ____ / ____</i> <i>(Requires Prior Administrative Approval From SMI Office to Sponsoring Department—not optional to participant.)</i>

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
			5/15/14 - 8/14/14	
	OR SPRING	1/15/14 - 8/14/14	OR 3 MONTHS	X/15/XX - X/14/XX
	1/15/14 - 6/14/14		X/15/XX - X/14/XX	
	\$199.25	\$278.95	\$119.55	\$39.85

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

Cash, Check or Money Order Enclosed Make check payable to SUNY at Buffalo	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.

_____	TODAY'S DATE: ____ / ____ / ____
APPLICANT'S SIGNATURE	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 / RE? YES NO

Roster Update: _____