ENROLLMENT FORM FOR INTERNATIONAL STUDENT HEALTH INSURANCE

Academic Policy Year: 2016-2017

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

PLEASE CIRCLE YOUR STATUS:

International Student in USA 1	International Scholar in USA 2	International Student on Practical Training (must attach practical training authorization papers) 3

_____ _____ ___ DATE OF BIRTH: _____ / _____ / _____
LAST NAME FIRST NAME MI Mo. Day Year

_____ _____ _____ _____ _____
U.S. MAILING ADDRESS TOWN/CITY STATE ZIP CODE

(____) _____ - _____ _____ _____ _____ _____ _____
U.S. TELEPHONE EMAIL ADDRESS UB DEPT OR PROGRAM HOME COUNTRY VISA TYPE

___ ___ ___ ___ - ___ ___ ___ ___
UB PERSON NUMBER

O MALE or O 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 / ____

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/16 - 1/14/17		5/15/17 - 8/14/17	
8/15/16-8/14/17	**OR SPRING**	1/15/17 - 8/14/17	**OR 3 MONTHS**	X/15/XX - X/14/XX
	1/15/17 - 6/14/17		X/15/XX - X/14/XX	
$1,302.00	$542.50	$759.50	$325.50	$108.50

Please indicate payment (circle one): **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)

I wish to enroll in 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 off of the international insurance plan for the specified period.

_____ 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: ____

OSA: _____ HTH: _____ Previously GSEU / RF? YES NO

Roster Update: _____