STATE UNIVERSITY OF NEW YORK AT BUFFALO

Waiver of SUNY Sponsored Medical Insurance

For Sponsored International Exchange and Study Abroad Programs

Health and accident insurance including coverage for medical evacuation and repatriation is **mandatory** for all participants on SUNY sponsored International Exchange and Study Abroad programs. Those who do not have adequate coverage must purchase the benefit plan provided through SUNY.

If you have adequate private coverage for the entire duration of your SUNY sponsored program abroad, you must **provide proof of your insurance** by including a photocopy of your insurance ID card with this waiver form.

Please read carefully, then sign and date the waiver statement below.

WAIVER OF SUNY INTERNATIONAL PLAN WHILE ON STUDY ABROAD

I, the undersigned, certify that I have been informed of the SUNY International Student and Scholar Health Insurance Plan and freely elect to waive my right to participate. I will be covered by a health and accident insurance policy for the duration of my study abroad. My insurance will be provided by _____, and my policy ID number will be _____. I have confirmed with my insurance company that I will be adequately covered while abroad and that claim's payment can be made for medical services received outside of the United States. Furthermore, I agree to hold harmless the University at Buffalo, SUNY, Sub-Board I, Inc. and all agencies and agents of the aforesaid organizations for any medical expenses incurred while participating in SUNY sponsored International Exchanges , Study Abroad Programs, or any other SUNY affiliated travels abroad.

_____

Print Name

_____

UB Person Number or Social Security Number

_____

Study Abroad Location

_____

Citizenship

_____

Applicant's Signature Date

_____

Parent/Guardian Signature (if student is under 18) Date

INSURANCE COMPANY:
Please return this form ASAP
By Fax: 716-645-3465
By Mail: University at Buffalo Medical Insurance, Suite 315 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 acknowledgement at the bottom of the form. All monetary units must be expressed be expressed in U.S. dollars.

Student Name: _____ Person number: _____
Last Name First Name MI

Insurance Company Name: _____ Policy Number: _____

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

_____ ___/___/___
Insuarnce Representative Name Insurance 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 persmission 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

ENROLLMENT FORM FOR MEDICAL EVACUATION AND REPATRIATION INSURANCE

Academic Policy Year: 2014-2015

SEMESTER (circle one): FALL SPRING SUMMER

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

If you have already contracted the SUNY International Health Insurance, *do not* complete this form.

PLEASE CIRCLE YOUR STATUS:

International Student in USA or RA/GA/TA	International Scholar in USA	International Student on Practical Training (must attach practical training Authorization papers)	American Student Studying Abroad - *Traveling to:*	American Faculty Abroad

LAST NAME _____ FIRST NAME _____ MI ___ DATE OF BIRTH: ____ / ____ / ____ 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 /____

Alternative Coverage Dates: FROM _____ /_____ /_____ TO _____ /_____ /_____
(Requires Prior Administrative Approval From SMI Office to Sponsoring Department—not optional to participant.)

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/14 - 1/14/15		5/15/15 - 8/14/15	
8/15/14-8/14/15	**OR SPRING**	1/15/15 - 8/14/15	**OR 3 MONTHS**	X/15/XX - X/14/XX
	1/15/15 - 6/14/15		X/15/XX - X/14/XX	
$88.80	$37.00	$51.80	$22.20	$7.40

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 on the SUNY sponsored Medex 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 SUNY sponsored Medical Evacuation and Repatriation coverage for the above specified dates.

_____ 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: 8

OSA: _____ E-Mailed/Handed MEDEX Card: _____