International Student Health Insurance Waiver

2015-2016

ATTENTION

The health insurance waiver now has an online component to it. If you will be seeking a waiver, you will first need to have your insurance company complete the "Clarification of Benefits" form.

Once the "Clarification of Benefits" form is completed, use the information to submit the online waiver. The link to the online waiver is: **http://hthworldwide.force.com/SUNY**

If you are using OHIP or Aetna Health Insurance (as part of SACM) please contact the office for a "Special Circumstance Waiver."

After your waiver is submitted through the online waiver system, you would turn in the completed waiver and clarification of benefits form to the Student Medical Insurance Office—315 Student Union.

INTERNATIONAL HEALTH INSURANCE WAIVER FORM

ACADEMIC YEAR: 2015-2016 SEMESTER (CIRCLE ONE): FALL SPRING SUMMER

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

PLEASE SUBMIT TO: SUITE 315 STUDENT UNION , SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 / FAX: (716) 645-3465 / PDF E-MAIL: ASKSM@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.) **All waivers must be accompanied with proof of enrollment.** (A photocopy of an insurance ID card or a letter from your employer/government stating effective dates of coverage—*all private insurance must be in effect by the first day of classes in order to waive the University Insurance policy*).
3.) **Any student presenting a privately held insurance policy for waiver may be e-mailed at the address provided below and required to provide a Clarification of Benefits form in order to determine the comparability of the private policy to SUNY's requirements.**
4.) **Submission Deadline for FALL 2015 waivers: OCTOBER 14, 2015**
   a. **Late Waiver Submission Deadline: NOVEMBER 24, 2015**
   (All late waivers must be accompanied by a $50.00 processing fee payable to "Sub-Board I, Inc.")

APPLICANTS MUST COMPLETE ALL FIELDS:

_____ _____ _____ DATE OF BIRTH: _____/_____/_____
LAST NAME FIRST NAME MI 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 O MALE or O FEMALE

NAME OF COMPANY/AGENCY ISSUING YOUR POLICY:_____

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

ARE YOU A STUDENT COVERED BY A SPONSORING AGENCY (FULBRIGHT, YOUR EMBASSY, ETC.) ? O YES _____ or O 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 2016 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2016-2017 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 DESCRETION. **I UNDERSTAND THAT IF I USE THE LAB OR 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.**

_____ DATE: _____/_____/_____
APPLICANT'S SIGNATURE Mo. Day Year

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FOR OFFICE USE ONLY: DATE PROCESSED _____/_____/_____

O Accepted
O Deleted from roster

O Accepted with MEDEX
O Letter of notification
O Enrolled into Class 8 Date:_____

O Denied
O Letter of notification

OSA_____ HTH_____

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 - INBOUND INTERNATIONAL

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. Deductible Amount $_____
4. Accidental Death Benefit $_____
5. Didmemberment Benefit $_____
6. Are pre-existing conditions covered? YES NO
   Duration of possible waiting period? _____ Months
   *Has it been met? YES NO
7. Is medical evacuation covered? YES NO
   To what amount? $_____
8. Is repatriation covered? YES NO
   To what amount? $_____
9. Maximum daily benefit for in-hospital room & board $_____
10. Are outpatient emotional and mental disorders covered? YES NO
    To what amount? $_____
11. Are inpatient emotional and mental disorders covered? YES NO
    To what amount? $_____
12. Is outpatient alcholism and substance abuse covered? YES NO
    To what amount? $_____
13. Are prescription drugs covered? YES NO Limit: $_____
14. Are x-rays and lab work covered? YES NO Limit: $_____
15. Are ambulance charges and medical equipment rental expenses covered? YES NO Limit: $_____

_____ ___/___/___
Insurance 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