## INTERNATIONAL HEALTH INSURANCE WAIVER FORM

## (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: 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 a 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 2016 waivers: OCTOBER 12, 2016

OSA

a. Late Waiver Submission Deadline: NOVEMBER 22, 2016 (\$50 Late-Fee)

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.)?  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 2017 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 20 2018 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 INSURANC 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 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:  DATE:  APPLICANT'S SIGNATURE  DATE:  DATE:  DATE PROCESSED  J MO. Day Year	APPLICANTS MUST COMPLETE AL	L FIELDS:						
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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:		Perso	on number:	
Last Name First Name Insurance Company Name:	MI Po	licy Number:		
1. Effective dates of coverage	/ /	Through	/	/
2. Total maximum benefit amount		\$		
3. Deductible Amount		\$		•
1. Accidental Death Benefit		\$		•
5. Didmemberment Benefit		\$		
5. Are pre-existing conditions covered?  Duration of possible waiting period?  *Has it been met?	YES YES		NO Months NO	
7. Is medical evacuation covered?  To what amount?	YES	\$	NO	
3. Is repatriation covered?  To what amount?	YES	\$	NO	
9. Maximum daily benefit for in-hospital room & board		\$		
10. Are outpatient emotional and mental disorders covered? To what amount?	YES	\$	NO	
11. Are inpatient emotional and mental disorders covered?  To what amount?	YES	\$	NO	
12. Is outpatient alcholism and substance abuse covered? To what amount?	YES	\$	NO	
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: \$
nsurance Representative Name Insurance Represe	ntative Sign	ature	Phone	Date
I affirm all of the supplied information above is truthful. I take full reto hold harmless the University at Buffalo/Sub Board I, Inc. for any i limitations of my private health insurance coverage. I give persmissi SBI Student medical Insurance Office at the University at Buand to file for statistical use and use of	ncorrect transl on for enrollm ffalo for the pu	ation or medical o ent and benefit ir rpose of attempt	expenses I may in formation to be ing an insurance	incur due to the e released to the
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Policy Holder Signature Date			Policy Hole	der's Email Address