INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM

THIS WAIVER IS FOR INTERNATIONAL J-1 SCHOLARS AND THEIR J-2 DEPENDENTS ONLY!

PLEASE RETURN TO: SUITE 223 STUDENT UNION, SUNY AT BUFFALO – NORTH CAMPUS, BUFFALO, NY 14260 PH: (716) 645-3036 – FAX: (716) 645-2465 – E-MAIL: ASKSMI@BUFFALO.EDU

APPLICANT MUST PRINT & COMPLETE ALL FIELDS!

ALL WAIVERS MUST BE ACCOMPANIED BY PROOF OF ENROLLMENT. A photocopy of the private insurance card or a certification of coverage in English from the scholar's home university or employer are acceptable as proof of enrollment.

Most scholars attempting to waive SUNY's medical insurance with a foreign insurer will be required to have a Clarification of Beneifts form completed. The scholar will be notified if this is required when he/she comes to the UB Student Medical Insurance Office or via e-mail with the required document attached. The Clarification of Benefits must be sigend by the scholar, then forwarded to the private insurance company to be completed and certified. The completed form must be returned to the UB Student Medical Insurance Office before a determination can be reached as to the scholar's eligibility for waiver.

As per U.S. Immigration & SUNY requirements, each visiting J-1 Scholar (along with any and all J-2 Dependents) must contract sufficient medical insurance or show proof of sufficient private insurance to the UB Student Medical Insurance Office within 31 days of entering the United States. This is a Visa proviso for all J-Visa holders and failure to comply will put the scholar's (and dependent's if applicable) Visa status in jeopardy.

LAST NAME	FIRST NAM		DATE OF BIRT	H:/ Mo. Day Year
U.S. MAILING ADDRESS		CITY	STATE	ZIP CODE
U.S. TELEPHONE NUMBER	E-MAIL ADDRESS	UB DEPARTMENT	PROGRAM	HOME COUNTRY
UB PERSON NUMBER	SOCIAL SECURITY NUMBER	VISA STATUS	Ом	ALE or OFEMALE
NAME OF INSURANCE COMPANY ISSUI	ING YOUR POLICY:			
HAVE YOU WAIVED UB'S INSURANCE II	OLICY ?	O YES or	O NO	
ARE YOU COVERED BY A SPONSORING AGENCY (E.G. FULBRIGHT, YOUR EMBASSY, ETC.) ?			O YES or O NO	
EVERY POLICY ITEM MANDATED E ALSO UNDERSTAND THIS WAIVER YEAR—ACADEMIC YEARS END ON YEAR DURING THE MONTH OF JUL WITH SUNY AT BUFFALO. I ALSO F BOARD I, INC. FOR ANY AND ALL M INSURANCE COVERAGE. THE UB: INFORMATION AS WELL AS DENY A ITHE LAB OR PHARMACY IN MICHA INTERNATIONAL INSURANCE PLAN FROM THE POINT OF MY USEAGE. SIGNA	R IS CONSIDERED EFFECTIVE ON I 14 TH AUGUST. THUS, I MUST SULY OR AUGUST IF I PLAN TO REMFULLY AGREE TO HOLD HARMLE: MEDICAL EXPENSES I MAY INCUR STUDENT MEDICAL INSURANCE AND/OR REVOKE ANY WAIVER ASEL HALL ON THE UB SOUTH CAMN, I WILL BE CHARGED RETROAC	NLY THROUGH THE E IBMIT ANOTHER WAI AIN IN THE UNITED S SS SUNY, THE UNIVE DUE TO THE LIMITA OFFICE HAS THE RIC T THEIR DESCRETIO IPUS AND HAVE THE TIVELY FOR THE FU	END OF THE CUINTER FOR THE NOTATES AS A VISERSITY AT BUFF TIONS OF MY POSITY TO REQUES NOTATED TO REQUES NOTATED TO REQUES THE CHARGES BILL	RRENT ACADEMIC EXT ACADEMIC EXT ACADEMIC SITING SCHOLAR ALO AND SUB- RIVATE HEALTH EXT ADDITIONAL ND THAT IF I USE ED TO THE SUNY URANCE PREMIUM
FOR OFFICE USE ONLY:	DATE PROCESSE	D/	SUNY-SM	л Agent:
O Accepted Fully Comparable	O Accepted with M O E-mail of Notifica O Enrolled as Clas		O E	enied Waiver -mail of Notification
Pharm/Lab/ ISSS Roster:	HTH Enrol	lment:		