ENROLLMENT FORM FOR INTERNATIONAL STUDENT HEALTH INSURANCE

Academic Policy Year: 2010-2011

PLEASE RETURN TO: SUITE 223 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

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 ___ ___ ___ ___ - ___ ___ ___ ___ ___ SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___ (Non-UB students only) 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
	8/15/10 - 1/14/11		5/15/11 - 8/14/11	
8/15/10-8/14/11	**OR SPRING**	1/15/11 - 8/14/11	**OR 3 MONTHS**	X/15/XX - X/14/XX
	1/15/11 - 6/14/11		X/15/XX - X/14/XX	
$1,089.75	$455.00	$637.00	$273.00	$91.00

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.

_____ APPLICANT'S SIGNATURE

TODAY'S DATE: ____ / ____ / ____ 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: _____