

ENROLLMENT FORM FOR INTERNATIONAL STUDENT HEALTH INSURANCE

Academic Policy Year: 2013-2014

SEMESTER (Circle One): FALL SPRING SUMMER

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 ☐ MALE or ☐ 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
	8/15/13 - 1/14/14		5/15/14 - 8/14/14	
8/15/13-8/14/14	OR SPRING	1/15/14 - 8/14/14	OR 3 MONTHS	X/15/XX - X/14/XX
	1/15/14 - 6/14/14		X/15/XX - X/14/XX	
\$1113.00	\$463.75	\$649.25	\$278.25	\$92.75

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

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: _____