

INTERNATIONAL HEALTH INSURANCE WAIVER FORM

ACADEMIC POLICY TERM: SPRING 2011

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

PLEASE SUBMIT 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 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 accomplished 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 Spring 2011 waivers: Tuesday 22 February 2011**
 - a. **Late Waiver Submission Deadline: Tuesday 22 March 2011**
(All late waivers must be accompanied by a \$50.00 processing fee payable to "Sub-Board I, Inc.")
 - b. No waiver requests will be accepted or considered past 22 March 2011.

APPLICANTS MUST COMPLETE ALL FIELDS:

LAST NAME FIRST NAME MI DATE OF BIRTH: ____/____/____
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 SOCIAL SECURITY NUMBER VISA TYPE ☐ MALE or ☐ FEMALE

NAME OF COMPANY/AGENCY ISSUING YOUR POLICY: _____

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

ARE YOU A STUDENT COVERED BY A SPONSORING AGENCY (FULBRIGHT, YOUR EMBASSY, ETC.) ? ☐ YES _____ or ☐ 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 2011 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2011-2012 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 DISCRETION. 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.

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

FOR OFFICE USE ONLY:

DATE PROCESSED ____/____/____

☐ Accepted

☐ Accepted with MEDEX

☐ Denied

☐ Deleted from roster

☐ Letter of notification

☐ Letter of notification

☐ Enrolled into Class 8 Date: _____

OSA _____

HTH _____