INTERNATIONAL HEALTH INSURANCE WAIVER FORM

ACADEMIC YEAR: 2012-13 SEMESTER (CIRCLE ONE): FALL SPRING SUMMER

(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 accompanied 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 will be required to turn in a Clarification of Benefits Form, completed by their insurance company, in order to determine the comparability of the private policy to SUNY's requirements.

4.) Submission Deadline for SPRING 2013 waivers: **February 27, 2013**
   a. Late Waiver Submission Deadline: **APRIL 3, 2013**
   (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 APRIL 3, 2013

_____ _____ ____ DATE OF BIRTH: ____/____/____
LAST NAME FIRST NAME MI 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 VISA TYPE O MALE or O FEMALE

NAME OF COMPANY/AGENCY ISSUING YOUR POLICY:_____

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.) ? O YES _____ or O 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 2013 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2013-2014 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 DESCRETION. **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.**

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

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FOR OFFICE USE ONLY: DATE PROCESSED ____/____/____

O Accepted
O Deleted from roster

O Accepted with MEDEX
O Letter of notification
O Enrolled into Class 8 Date:_____

O Denied
O Letter of notification

OSA_____ HTH_____

INSURANCE COMPANY
Please Return this Form ASAP
By Fax: 716-645-3466
By Mail: University at Buffalo Medical Insurance, Suite 223 Student Union, Buffalo, NY 14260
By E-mail PDF: AskSMI@buffalo.edu

CLARIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgment at the bottom of the form. All monetary units must be expressed both in the relevant foreign currency and in U.S. dollars at the current exchange rate.

Student Name: _____ _____ ___ UB Person #: _____
Last Name First Name MI

1. Effective dates of coverage _____ through _____
2. Total maximum benefit amount _____ $_____
3. Deductible amount _____ $_____
4. Accidental death benefit _____ $_____
5. Dismemberment benefit _____ $_____
6. Are pre-existing conditions covered? Yes ___ No ___
   Duration of possible waiting period? ___ Months
   *Has it been met? Yes ___ No ___
7. Is medical evacuation covered? Yes ___ No ___
   To what amount? _____ $_____
8. Is repatriation covered? Yes ___ No ___
   To what amount? _____ $_____
9. Maximum daily benefit for in-hospital room & board _____ $_____
10. Are outpatient emotional and mental disorders covered? Yes ___ No ___
    To what amount? _____ $_____
11. Are inpatient emotional and mental disorders covered? Yes ___ No ___
    To what amount? _____ $_____
12. Is outpatient alcoholism and substance abuse covered? Yes ___ No ___
    To what amount? _____ $_____
13. Are prescription drugs covered? Yes ___ No ___ Limit$_____
14. Are x-rays and lab work covered? Yes ___ No ___ Limit$_____
15. Are ambulance charges and medical equipment rental expenses covered? Yes ___ No ___ Limit$_____

_____ _____ _____ ___/___/___
Insurance Company's Name Representive Name(Please Print) Phone Number Date

I take full responsibility for the answers I have supplied above, and fully agree to hold harmless the University at Buffalo for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give permission for enrollment and benefit information to be released to the Student Medical Insurance Office at the University of Buffalo for the purpose of attempting an insurance waiver and to file *for statistical use and use of the participant for medical reasons.*

_____ ___/___/___ _____
Policy Holder's Signature Date Policy Holder's Email Address