SBI
Student Owned Services

STUDENT MEDICAL INSURANCE OFFICE
University at Buffalo • 223 Student Union, Buffalo, NY 14260
Tel: (716)645-3036 • Fax: (716)645-3465 • Web: www.healthinsurance.buffalo.edu

2010-2011 PRO RATA PREMIUM REFUND REQUEST FORM

(FOR USE ONLY FOR STUDENTS WITH SMI ENROLLMENT ENROLLED ON PARENT PLAN BY JANUARY 1, 2011 DUE TO HEALTH CARE LEGISLATION REFORM)

Student Name: _____

UB Person Number: _____

UB-IT E-mail Address: _____

If you currently carry private health insurance that meets or exceeds the requirements for waiver of the mandatory UB-AETNA program, you may still be eligible for a partial waiver of premium and participation. In order to continue with this process, please complete the following forms and return to the **STUDENT MEDICAL INSURANCE OFFICE NO LATER THAN FEBRUARY 1, 2011. ABSOLUTELY NO REFUND REQUEST WILL BE PROCESSED AFTER THIS DATE**.

Step One: Print and complete all three pages of refund request forms.

Step Two: Have the attached verification form completed by your private health insurance company. This form **must** be signed by a Representative at your insurance company with a valid telephone number provided for contact and verification purposes. Enrollment effective date must be between September 23, 2010 and January 1, 2011.

Step Three: Signed HIPPA release form for permission to verify coverage requirements for compliance to attend the University at Buffalo.

—Student Acknowledgement and Certification—

I understand that this pro-rata premium refund is based solely on my eligibility and enrollment on private health insurance through a parent plan on or before January 1, 2011 due to federal health care reform. I also understand that this is not a University at Buffalo based refund but is directed by the guidelines set forth from Aetna Student Health (aetnastudenthealth.com). Refund amount is based on premium component only. I also understand that by signing the attached HIPPA Release form the University at Buffalo may contact my private health insurance company to verify that my private health insurance meets or exceeds the requirement for attendance at the University and any requirements of this request. If my private health insurance does not meet all requirements set forth by the University at Buffalo, the request will be denied. If any portion of required documentation is not completed by February 1, 2011, no refund will be granted.

Student Signature: _____ Date: _____ / _____ / _____

University at Buffalo
Undergraduate/Graduate Student Plan
Insurance Verification Form

Copies of Insurance policies, Certificate of Creditable Coverage or ID Cards are not acceptable.

The University at Buffalo requires all qualifing students to maintain health insurance providing coverage for in-patient and out-patient, mental health, prescription drugs as well as catastrophic illness and injury. The student may satisfy the insurance requirements through private or employer sponsored plans that meet certain minimum criteria or through enrollment in a group insurance plan. Deadline for this form is February 1, 2011. All information must be complete and received at address below on or before 4pm on 2/1/11.

Section I (To Be Completed by Student)

Student Name: Last: _____ First: _____Phone Number: _____

UB Person #: _____ Email Address : _____

Student Address: _____

City: _____ State: _____ Zip: _____

Section II (MUST be completed by an Insurance Company Representative) PLEASE PRINT

Name of Insurance Company: _____ Is this plan a Medicaid Program: YES or NO
If yes, County: _____

Member Name: _____

Member ID Number: _____ Is this plan a Healthy NY Program: YES or NO

Group Number: _____ Policy Number _____

Effective Start Date: _____ Re-enrollment due to legislation reform (please circle one): YES or NO

Expiration Date: _____

I hereby attest that this plan meets the following standards:

Yes / No The subscriber's plan includes unlimited annual maximum coverage.
Aggregate yearly per member maximum of $_____

Yes / No The subscriber's plan will cover Inpatient and Outpatient medical care within 25 miles of the University at Buffalo campus area. ***Emergency Only coverage does not meet this requirement***.

Yes / No The subscriber's plan will cover Inpatient and Outpatient mental health care within 25 miles of the University at Buffalo campus area. ***Emergency Only coverage does not meet this requirement.***

Yes / No The subscriber's plan will cover prescription drugs (either as part of this medical plan or as a separate prescription plan).

_____
REQUIRED: Insurance Carrier Representative Name
(please print)

_____
Insurance Carrier Rep Direct Phone Number

Please Return To:
UB Student Medical Insurance Office
Suite 223 Student Union
Buffalo, NY 14260
Fax: (716) 645-3465
E-mail: asksmi@buffalo.edu

Sub-Board I, Inc.

AUTHORIZATION for HEALTH CARE / HEALTH INSURANCE ADVOCACY

Information about you and your health is personal and Sub-Board I, Inc. (SBI) is committed to protecting the privacy of such information. In addition, your personal health information (PHI) is, in many cases, protected from use and disclosure by both State and Federal law. As a result, SBI will not use your PHI to advocate on your behalf with respect to health care or health insurance matters unless you sign this form permitting SBI to use your PHI for this purpose. Please carefully read this form and the information set forth below before signing.

Patient/Student Name: _____ Person Number _____-_____

Address: _____

_____

DOB: _____ Telephone #: _____(day) _____(eve)

I herby authorize representatives of SBI to release/request information related to my medical care for the specified date(s) or type(s) of service to the specified insurer(s) and/or provider(s):

Date(s) and/or Type(s) of Service:

X Verification of health insurance enrollment and general policy benefits: _____**2010/2011**____

Providers:

☐ Health care from the following provider(s) only: _____
(Name of Insurance Company-more than one can be listed) Please specify individual provider(s)

Please specify individual insurer(s) and/or HMO(s)

By providing this authorization, I give permission for representative of SBI/Aetna to discuss my enrollment/benefits from private health care coverage that I receive from the above named insurance company. I understand that I can rescind this authorization at any time thereby affecting future (but not past) communications. If not earlier rescinded by me, this authorization shall expire on **8/21/2011**.
(specified expiration date)

_____ _____
Signature of Student Participant Signature of Parent if student younger than 18

_____
Date