

# INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM

**THIS WAIVER IS FOR INTERNATIONAL J-1 SCHOLARS AND THEIR J-2 DEPENDENTS ONLY!**

SEMESTER (CIRCLE ONE): FALL SPRING SUMMER

PLEASE RETURN TO: SUITE 223 STUDENT UNION, SUNY AT BUFFALO – NORTH CAMPUS, BUFFALO, NY 14260  
PH: (716) 645-3036 – FAX: (716) 645-2465 – E-MAIL: ASKSMI@BUFFALO.EDU

**APPLICANT MUST PRINT & COMPLETE ALL FIELDS!**

**ALL WAIVERS MUST BE ACCOMPANIED BY PROOF OF ENROLLMENT.** A photocopy of the private insurance card or a certification of coverage in English from the scholar's home university or employer are acceptable as proof of enrollment.

**Scholars attempting to waive SUNY's medical insurance with a foreign insurer will be required to have a Clarification of Benefits form completed.** The Clarification of Benefits must be signed completed by the private insurance company in order for the form to be accepted. The completed form must be signed by the scholar, returned to the UB Student Medical Insurance Office before a determination can be reached as to the scholar's eligibility for waiver.

As per U.S. Immigration & SUNY requirements, each visiting J-1 Scholar (along with any and all J-2 Dependents) must contract sufficient medical insurance or show proof of sufficient private insurance to the UB Student Medical Insurance Office within 31 days of entering the United States. This is a Visa proviso for all J-Visa holders and failure to comply will put the scholar's (and dependent's if applicable) Visa status in jeopardy.

\_\_\_\_\_  
LAST NAME                      FIRST NAME                      MI                      DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo.   Day   Year

U.S. MAILING ADDRESS CITY STATE ZIP CODE

( ) .  
U.S. TELEPHONE NUMBER E-MAIL ADDRESS UB DEPARTMENT / PROGRAM HOME COUNTRY

UB PERSON NUMBER VISA STATUS ☐ MALE or ☐ FEMALE

NAME OF INSURANCE COMPANY ISSUING YOUR POLICY: \_\_\_\_\_

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

ARE YOU COVERED BY A SPONSORING AGENCY (E.G. FULBRIGHT, YOUR EMBASSY, ETC.) ? ☐ YES \_\_\_\_\_ or ☐ NO  
PLEASE SPECIFY

I UNDERSTAND THAT A WAIVER MAY ONLY BE PROCESSED IF MY CURRENT HEALTH INSURANCE IS COMPARABLE TO EVERY POLICY ITEM MANDATED BY THE STATE OF NEW YORK AND U.S. IMMIGRATION SERVICES FOR MY VISA STATUS. I ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH THE END OF THE CURRENT ACADEMIC YEAR—ACADEMIC YEARS END ON 14<sup>TH</sup> AUGUST. THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE NEXT ACADEMIC YEAR DURING THE MONTH OF JULY OR AUGUST IF I PLAN TO REMAIN IN THE UNITED STATES AS A VISITING SCHOLAR (OR DEPENDENT OF SCHOLAR) WITH SUNY AT BUFFALO. I ALSO FULLY AGREE TO HOLD HARMLESS SUNY, THE UNIVERSITY AT BUFFALO AND SUB-BOARD I, INC. FOR ANY AND ALL MEDICAL EXPENSES I MAY INCUR DUE TO THE LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT MEDICAL INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AS WELL AS DENY AND/OR REVOKE ANY WAIVER AT THEIR DISCRETION. I UNDERSTAND THAT IF I USE THE LAB OR PHARMACY IN MICHAEL HALL ON THE UB SOUTH CAMPUS AND HAVE THE CHARGES BILLED TO THE SUNY INTERNATIONAL INSURANCE PLAN, I WILL BE CHARGED RETROACTIVELY FOR THE FULL MEDICAL INSURANCE PREMIUM FROM THE POINT OF MY USAGE.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

**FOR OFFICE USE ONLY:**

DATE PROCESSED        /        /

SUNY-SMI Agent:

☐ Accepted Fully Comparable

☐ Accepted with MEDEX  
☐ E-mail of Notification / In-person  
☐ Enrolled as Class 8 Date: \_\_\_\_\_

☐ Denied Waiver  
☐ E-mail of Notification

Pharm/Lab/ ISSS Roster:

HTH Enrollment:

**INSURANCE COMPANY**  
**Please Return this Form ASAP**

**By Fax: 716-645-3465**

**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 \_\_\_\_\_ Representative 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 \_\_\_\_\_