

University at Buffalo - Student and Dependent Insurance Plan

Blue Cross Blue Shield Western New York Insurance Company

Return To: 315 Student Union North Campus Buffalo, NY 14260

Complete all Student information. Incomplete information will delay processing!

UB HUB PERMANENT ADDRESS WILL BE ENTERED AS DEFAULT

Please Print

Student Name: _____
Last Name First Name MI

Date of Birth: ____/____/____
Month/Day/Year

Sex: Male ☐ Female ☐

Phone Number: () _____ - _____ STUDENT ID NUMBER _____ - _____

Email address: _____ @BUFFALO.EDU

List Dependents to be insured

| | Last Name: | First Name | Date of Birth | Notes: | Gender |
|--------|------------|------------|---------------|--------|--------|
| Spouse | | | | | M F |
| Child | | | | | M F |
| Child | | | | | M F |
| Child | | | | | M F |

3. Select Enrollment Plan-please circle

| Basic Plan | Annual Effective Date Aug. 22, 2017– Aug. 21, 2018 Deadline: | Spring/Summer Effective Date Jan. 22, 2018—Aug. 21, 2018 Deadline: | Summer Effective Date: May 22, 2018—Aug. 21, 2018 Deadline: | Off Cycle Effective Date: ____/22/____ - Aug. 21, 2018 Deadline: within 30 days |
|------------|--|--|---|---|
| Student | \$2,075.00 | \$1,227.00 | \$ 549.00 | |
| S & Spouse | \$4,149.00 | \$2,454.00 | \$1,097.00 | |
| S & Child | \$3,666.00 | \$2,172.00 | \$ 977.00 | |
| S & Family | \$8,311.00 | \$4,898.00 | \$2,168.00 | |

PLEASE COMPLETE AND SIGN THIS FORM.

4. Designate Payment Method: The premium will be added to your Bursar Bill. Students on Leave, Post Doc/Bach and LOA are required to pay by check or money order made payable to Sub Board One, Inc.

5. Notice to Student (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above.

I permit UB to provide Blue Cross Blue Shield with enrollment status for purposes of eligibility under this plan. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse and child(ren) can be made void. I understand that if it is later determined that I am not eligible (**see the brochure, pamphlet or Master Policy for eligibility guidelines**), the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

***Enrollment Guidelines:** For applications received and accepted after the effective date of the policy period, but before the established deadline, coverage will be effective the first date of that policy period. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. **Application to enroll late in the plan must be made within 30 days of loss of other coverage. A letter of creditable coverage from the prior insurance carrier must accompany the application.**

Signature: _____ Date: _____

| | | | |
|--|--|---|----------------------|
| Staff Use: Enrolled <input type="checkbox"/> | Staff Use: S/A Billed <input type="checkbox"/> | Staff Use: payment <input type="checkbox"/> Receipt # _____ | Staff Use: P/I _____ |
|--|--|---|----------------------|