

INTERNATIONAL HEALTH INSURANCE WAIVER FORM

ACADEMIC YEAR: 2011-12 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 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 2012 waivers: FEBRUARY 25, 2012**
 - a. **Late Waiver Submission Deadline: MARCH 24, 2012**
(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 March 24, 2012**

APPLICANTS MUST COMPLETE ALL FIELDS:

_____		_____		_____		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		
_____		_____		O MALE or O FEMALE				
UB PERSON NUMBER		VISA TYPE						

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 2012 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2012-2013 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.

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

FOR OFFICE USE ONLY:

DATE PROCESSED ____/____/____

- | | | |
|---|---|--|
| <input type="radio"/> Accepted | <input type="radio"/> Accepted with MEDEX | <input type="radio"/> Denied |
| <input type="radio"/> Deleted from roster | <input type="radio"/> Letter of notification | <input type="radio"/> Letter of notification |
| | <input type="radio"/> Enrolled into Class 8 Date: _____ | |

OSA _____

HTH _____