INTERNATIONAL HEALTH INSURANCE WAIVER FORM

(This waiver form is for SUNY at Buffalo international students only.)

PLEASE SUBMIT TO: 1CAPEN , SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 / FAX: (716) 645-3948/ 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.) **Any student presenting a privately held insurance policy for waiver must provide a Clarification of Benefits form, completed by the insurance company or Human Resources department, in order to determine the comparability of the private policy to SUNY's requirements. A copy of your insurance ID card must be submitted with the wavier.**
3.) **Submission Deadline for FALL 2018 waivers: OCTOBER 10, 2018**
    a. **Late Waiver Submission Deadline: NOVEMBER 14, 2018 ($50 Late-Fee)**

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

___ ___ ___ ___ - ___ ___ ___ ___ _____
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 2019 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2019-2020 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 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 Accepted with MedEvac
O Letter of notification
O Denied
O Letter of notification

OSA_____ HTH_____

INSURANCE COMPANY/HR Representative:

Please return this form to the STUDENT/SCHOLAR ASAP

CLARIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company or Human Resources Department. You must also sign the acknowledgement at the bottom of the form. All monetary units must be expressed in U.S. dollars.

Student Name: _____ Person number: _____

Last Name First Name MI

Insurance Company Name: _____ Policy Number: _____

1. Effective dates of coverage ____/____/____ Through ____/____/____

2. Is the insurance plan a U.S. based policy? YES NO

(Please note that the NY State Essential Plan Four is not accepted and will not cover this requirement)

If no, please complete the supplemental clarification of benefits form.

3. Is the insurance plan fully ACA-compliant? YES NO

_____ ____/____/____

Insurance/HR Representative Name Insurance/HR Representative Signature Phone Date

I affirm all of the supplied information above is truthful. I take full responsibility for the answers I have supplied above, and fully agree to hold harmless the University at Buffalo/Sub Board I, Inc. for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give persmission for enrollment and benefit information to be released to the SBI Student medical Insurance Office at the University at 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 Signature Date Policy Holder's Email Address

INSURANCE COMPANY/HR Representative:
Please return this form to the Student/Scholar ASAP

SUPPLEMENTAL CLARIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgement at the bottom of the form. All monetary units must be expressed be expressed in U.S. dollars.

Student Name: _____ Person number: _____
Last Name First Name MI

Insurance Company Name: _____ Policy Number: _____

1. Effective dates of coverage ___/___/___ Through ___/___/___
2. Total maximum benefit amount $_____
3. Are pre-existing conditions covered? YES NO
4. Does plan directly pay benefits to providers in the USA? YES NO
5. Is medical evacuation covered? YES NO
   To what amount? $_____
6. Is repatriation covered? YES NO
   To what amount? $_____
7. Maximum daily benefit for in-hospital room & board $_____
8. Are outpatient emotional and mental disorders covered? YES NO
   To what amount? $_____
9. Are inpatient emotional and mental disorders covered? YES NO
   To what amount? $_____
10. Is outpatient alcholism and substance abuse covered? YES NO
    To what amount? $_____
11. Are prescription drugs covered? YES NO
12. Are x-rays and lab work covered? YES NO
13. Are ambulance charges and medical equipment rental expenses covered? YES NO

_____ ___/___/___
Insuarnce/HR Representative Name Insurance/HR Representative Signature Phone Date

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