

ENROLLMENT FORM FOR INTERNATIONAL STUDENT HEALTH INSURANCE

Academic Policy Year: 2008-2009

*PLEASE RETURN TO: SUITE 223 STUDENT UNION, SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 / FAX: (716) 645-3465 / E-MAIL: ASKSMI@BUFFALO.EDU*

PLEASE CIRCLE YOUR STATUS:

International Student in USA 1	International Scholar in USA 2	International Student on Practical Training (must attach practical training authorization papers) 3
--	--	--

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH: ____ / ____ / ____
Mo. Day Year

PREFERRED MAILING ADDRESS _____ City _____ State _____ Zip Code _____

(____) _____ - _____ HOME TELEPHONE _____ EMAIL ADDRESS _____ UB DEPARTMENT OR PROGRAM _____ HOME COUNTRY _____ VISA TYPE _____

UB PERSON NUMBER _____ SOCIAL SECURITY NUMBER _____ MALE or FEMALE
(Non-UB students only)

CURRENT EDUCATIONAL LEVEL: (CIRCLE ONE) UNDERGRAD GRADUATE PROFESSIONAL FACULTY/STAFF/RESEARCH

The insurance runs from the 15th to the 15th of each month. For example, if you want coverage from Feb. 1 to Mar. 10, you would have to pay for two whole months (enrolling Jan. 15 thru Mar. 15). There are no exceptions without prior approval of the insurance office.

DATES OF COVERAGE : FROM ____ / 15 / ____ TO ____ / 15 / ____
--

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/08 - 1/14/09		5/15/09 - 8/14/09	
8/15/08-8/15/09	OR SPRING	1/15/09 - 8/14/09	OR 3 MONTHS	X/15/XX - X/15/XX
	1/15/09 - 6/15/09		X/15/XX - X/15/XX	
\$951.00	\$396.25	\$554.75	\$237.75	\$79.25

Please indicate payment (circle one): **STUDENTS MUST HAVE THEIR STUDENT ACCOUNT BILLED.**

<input type="checkbox"/> Check or money order enclosed Make check payable to SUNY at Buffalo	<input type="checkbox"/> Please bill my student account (double check your person number above)	<input type="checkbox"/> Please invoice my department (prior approval from insurance office required)
--	--	--

I wish to enroll on the SUNY Buffalo International Health Insurance program I have circled above. I understand this includes insurance premium and a non-refundable administrative fee. I understand that by signing this enrollment form, I decline the option of waiving off of the international insurance plan before the end of the policy year.

SIGNATURE

TODAY'S DATE: ____ / ____ / ____
Mo. Day Year

=====

FOR OFFICE USE ONLY:

Check number: _____ Receipt number: _____ Payment amount \$: _____ Received by: _____

Effective Date ____/____/____ Expiration Date ____/____/____ Class: _____

OSA: _____ HTH: _____ Previously GSEU / RF? YES NO

Roster Update: _____