

# INTERNATIONAL HEALTH INSURANCE WAIVER FORM

## ACADEMIC POLICY TERM: FALL 2009

(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](mailto: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 accomplished 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 Fall 2009 waivers: Tuesday October 6, 2009**
  - a. **Late Waiver Submission Deadline: Tuesday November 3, 2009**  
**(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 November 3, 2009.

### 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	SOCIAL SECURITY NUMBER	VISA TYPE	<input type="radio"/> MALE or <input type="radio"/> FEMALE

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 AUGUST 14, 2010 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2010-2011 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 |

Enrolled into Class 8 Date: \_\_\_\_\_

OSA \_\_\_\_\_

HTH \_\_\_\_\_