

INTERNATIONAL HEALTH INSURANCE WAIVER FORM

Spring 2009

THIS WAIVER IS FOR INTERNATIONAL STUDENTS ONLY!!

PLEASE MAIL TO: STUDENT UNION, SUITE 223, SUNY BUFFALO, BUFFALO, NY 14260

PLEASE PRINT! CAREFULLY READ AND ANSWER ALL QUESTIONS!

INCOMPLETE WAIVERS WILL NOT BE PROCESSED AND WILL BE SUBJECT TO LATE FEES PAYABLE TO THIS OFFICE AND/OR THE STUDENT RESPONSE CENTER.

ALL WAIVERS MUST BE ACCOMPANIED BY PROOF OF ENROLLMENT. (A PHOTOCOPY OF AN INSURANCE ID CARD OR A LETTER FROM YOUR EMPLOYER 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).

If your insurance is anything other than UNIVERA, INDEPENDENT HEALTH, COMMUNITY BLUE, EMPIRE PLAN OR OHIP, and you have not waived UB insurance with this alternate policy in a previous year, YOU MUST SUBMIT A COPY OF YOUR INSURANCE POLICY TRANSLATED INTO ENGLISH WITH YOUR WAIVER. If you do not have a translated copy of your policy, you must request a CLARIFICATION OF BENEFITS FORM for your insurance company to complete.

WAIVERS SUBMITTED AFTER **17 February 2009** MUST BE ACCOMPANIED BY A CHECK OR MONEY ORDER FOR \$50 PAYABLE TO SUB-BOARD ONE, INC. **NO EXCEPTIONS!!!** NO WAIVERS FOR THE SPRING 2009 SEMESTER WILL BE ACCEPTED AFTER **17 March 2009. ABSOLUTELY NO EXCEPTIONS!!!!**

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

ADDRESS (Street) (City) (State) (Zip Code)

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

____ - ____ - ____ - ____ - ____ - ____
UB PERSON NUMBER SOCIAL SECURITY NUMBER VISA STATUS MALE or FEMALE

NAME OF INSURANCE COMPANY 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 WHICH ONE

I UNDERSTAND THAT A WAIVER MAY ONLY BE PROCESSED IF THE HEALTH INSURANCE I AM PRESENTLY ENROLLED IN IS COMPARABLE TO EVERY POLICY ITEM MANDATED BY THE STATE OF NEW YORK. I ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH 15 AUGUST 2009 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE FALL 2009 SEMESTER. I ALSO FULLY AGREE NOT TO HOLD THE UNIVERSITY AT BUFFALO LIABLE FOR ANY MEDICAL EXPENSES I MAY INCUR DUE TO LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE STUDENT MEDICAL INSURANCE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION OR DENY ANY REQUEST FOR A 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.

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

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FOR OFFICE USE ONLY:

DATE PROCESSED ____/____/____

- Accepted Accepted with MEDEX Denied
 Deleted from roster Letter of notification Letter of notification
 Enrolled into Class 8 Date: _____

OSA _____

HTH _____