

**INSURANCE COMPANY**

**Please Return this Form ASAP**

**By Fax: 716-645-3465**

**By Mail: University at Buffalo Medical Insurance, Suite 223 Student Union, Buffalo, NY 14260**

**By E-mail PDF: AskSMI@buffalo.edu**

**CLARIFICATION OF INSURANCE POLICY BENEFITS**

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgment at the bottom of the form. All monetary units must be expressed both in the relevant foreign currency and in U.S. dollars at the current exchange rate.

Student Name: \_\_\_\_\_ UB Person #: \_\_\_\_\_  
Last Name First Name MI

- 1. Effective dates of coverage \_\_\_\_\_ through \_\_\_\_\_
- 2. Total maximum benefit amount \_\_\_\_\_ \$ \_\_\_\_\_
- 3. Deductible amount \_\_\_\_\_ \$ \_\_\_\_\_
- 4. Accidental death benefit \_\_\_\_\_ \$ \_\_\_\_\_
- 5. Dismemberment benefit \_\_\_\_\_ \$ \_\_\_\_\_
- 6. Are pre-existing conditions covered? Yes \_\_\_ No \_\_\_  
Duration of possible waiting period? \_\_\_ Months  
\*Has it been met? Yes \_\_\_ No \_\_\_
- 7. Is medical evacuation covered? Yes \_\_\_ No \_\_\_  
To what amount? \_\_\_\_\_ \$ \_\_\_\_\_
- 8. Is repatriation covered? Yes \_\_\_ No \_\_\_  
To what amount? \_\_\_\_\_ \$ \_\_\_\_\_
- 9. Maximum daily benefit for in-hospital room & board \_\_\_\_\_ \$ \_\_\_\_\_
- 10. Are outpatient emotional and mental disorders covered? Yes \_\_\_ No \_\_\_  
To what amount? \_\_\_\_\_ \$ \_\_\_\_\_
- 11. Are inpatient emotional and mental disorders covered? Yes \_\_\_ No \_\_\_  
To what amount? \_\_\_\_\_ \$ \_\_\_\_\_
- 12. Is outpatient alcoholism and substance abuse covered? Yes \_\_\_ No \_\_\_  
To what amount? \_\_\_\_\_ \$ \_\_\_\_\_
- 13. Are prescription drugs covered? Yes \_\_\_ No \_\_\_ Limit\$ \_\_\_\_\_
- 14. Are x-rays and lab work covered? Yes \_\_\_ No \_\_\_ Limit\$ \_\_\_\_\_
- 15. Are ambulance charges and medical equipment rental expenses covered? Yes \_\_\_ No \_\_\_ Limit\$ \_\_\_\_\_

\_\_\_\_\_  
Insurance Company's Name Representative Name(Please Print) Phone Number / /  
Date

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