INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM

THIS WAIVER IS FOR INTERNATIONAL J-1 SCHOLARS AND THEIR J-2 DEPENDENTS ONLY!

PLEASE RETURN TO: SUITE 223 STUDENT UNION, SUNY AT BUFFALO – NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 – FAX: (716) 645-2465 – E-MAIL: ASKSMI@BUFFALO.EDU

APPLICANT MUST PRINT & COMPLETE ALL FIELDS!

ALL WAIVERS MUST BE ACCOMPANIED BY PROOF OF ENROLLMENT. A photocopy of the private insurance card or a certification of coverage in English from the scholar's home university or employer are acceptable as proof of enrollment.

Most scholars attempting to waive SUNY's medical insurance with a foreign insurer will be required to have a Clarification of Beneifts form completed. The scholar will be notified if this is required when he/she comes to the UB Student Medical Insurance Office or via e-mail with the required document attached . The Clarification of Benefits must be sigend by the scholar, then forwarded to the private insurance company to be completed and certified. The completed form must be returned to the UB Student Medical Insurance Office before a determination can be reached as to the scholar's eligibility for waiver.

As per U.S. Immigration & SUNY requirements, each visiting J-1 Scholar (along with any and all J-2 Dependents) must contract sufficient medical insurance or show proof of sufficient private insurance to the UB Student Medical Insurance Office within 31 days of entering the United States. This is a Visa proviso for all J-Visa holders and failure to comply will put the scholar's (and dependent's if applicable) Visa status in jeopardy.

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

_____ _____ _____ _____
U.S. MAILING ADDRESS CITY STATE ZIP CODE

(_____) _____ - _____ _____ _____ _____
U.S. TELEPHONE NUMBER E-MAIL ADDRESS UB DEPARTMENT / PROGRAM HOME COUNTRY

___ ___ ___ ___ - ___ ___ ___ ___ ___ ___ ___ - ___ ___ - ___ ___ ___ ___ _____
UB PERSON NUMBER SOCIAL SECURITY NUMBER VISA STATUS O MALE or O FEMALE

NAME OF INSURANCE COMPANY ISSUING YOUR POLICY:_____

HAVE YOU WAIVED UB'S INSURANCE IN A PREVIOUSLY WITH THIS SAME POLICY ? O YES or O NO

ARE YOU COVERED BY A SPONSORING AGENCY (E.G. FULBRIGHT, YOUR EMBASSY, ETC.) ? O YES _____ or O NO
PLEASE SPECIFY

I UNDERSTAND THAT A WAIVER MAY ONLY BE PROCESSED IF MY CURRENT HEALTH INSURANCE IS COMPARABLE TO EVERY POLICY ITEM MANDATED BY THE STATE OF NEW YORK AND U.S. IMMIGRATION SERVICES FOR MY VISA STATUS. I ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH THE END OF THE CURRENT ACADEMIC YEAR—ACADEMIC YEARS END ON 14TH AUGUST. THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE NEXT ACADEMIC YEAR DURING THE MONTH OF JULY OR AUGUST IF I PLAN TO REMAIN IN THE UNITED STATES AS A VISITING SCHOLAR WITH SUNY AT BUFFALO. I ALSO FULLY AGREE TO HOLD HARMLESS SUNY, THE UNIVERSITY AT BUFFALO AND SUB-BOARD I, INC. FOR ANY AND ALL MEDICAL EXPENSES I MAY INCUR DUE TO THE LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT MEDICAL INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AS WELL AS DENY AND/OR REVOKE ANY WAIVER AT THEIR DESCRETION. I UNDERSTAND THAT IF I USE THE LAB OR PHARMACY IN MICHAEL HALL ON THE UB SOUTH CAMPUS AND HAVE THE CHARGES BILLED TO THE SUNY INTERNATIONAL INSURANCE PLAN, I WILL BE CHARGED RETROACTIVELY FOR THE FULL MEDICAL INSURANCE PREMIUM FROM THE POINT OF MY USEAGE.

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

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FOR OFFICE USE ONLY: DATE PROCESSED _____/_____/_____ SUNY-SMI Agent: _____

O Accepted Fully Comparable
O Accepted with MEDEX
O E-mail of Notification / In-person
O Enrolled as Class 8 Date: _____
O Denied Waiver
O E-mail of Notification

Pharm/Lab/ ISSS Roster: _____ HTH Enrollment: _____