

MEDICAL EVACUATION AND REPATRIATION ENROLLMENT FORM 2025-2026

The University at Buffalo is committed to ensuring equal access to information. As part of this commitment, university content must be accessible to everyone, including individuals with physical, sensory, or cognitive impairments, with or without the use of assistive technology. If you encounter an accessibility issue when completing this form, please contact the Student Health Insurance office.

PLEASE SUBMIT TO: ASKSHI@BUFFALO.EDU

LAST NAME FIRST NAME MI DATE OF BIRTH: ____/____/____
MONTH DAY YEAR

U.S. MAILING ADDRESS CITY STATE ZIP CODE

(____)____-_____
U.S. TELEPHONE EMAIL ADDRESS HOME COUNTRY VISA TYPE

UB PERSON NUMBER ☐ MALE ☐ FEMALE ☐ UNDISCLOSED ☐ NONBINARY

SELECT COVERAGE PERIOD:

<input type="radio"/>	ANNUAL 8/15/2025- 8/14/2026	\$90.00
<input type="radio"/>	MONTHLY <u>XX/15/XX – XX/14/XX</u>	\$7.50

*FOR MONTHLY RATE, WRITE DATES OF COVERAGE: ____/15/____ TO ____/14/____

ALL UB STUDENTS MUST HAVE STUDENT ACCOUNT BILLED FOR THE HEALTH INSURANCE. DEPARTMENTAL INVOICES ARE AVAILABLE WITH PRIOR APPROVAL FROM THE HEALTH INSURANCE OFFICE. SHI OFFICE DOES NOT ACCEPT CASH OR CHECKS. ALL STUDENTS ON F-1 OPT AND J-1 SCHOLARS WILL RECEIVE A PAYMENT LINK TO THE EMAIL ADDRESS PROVIDED. THE PRICING LISTED IS EFFECTIVE FOR THE 2025-2026 POLICY YEAR UNTIL AUGUST 14, 2026.

I WISH TO ENROLL IN THE MEDICAL EVACUATION AND REPATRIATION COVERAGE FOR THE ABOVE PERIOD. I UNDERSTAND THIS INCLUDES PAYMENT OF THE INSURANCE PREMIUM AND A NON-REFUNDABLE ADMINISTRATIVE FEE. I UNDERSTAND THAT BY SIGNING THIS ENROLLMENT FORM, I HAVE OPTED OUT OF THE SUNY INTERNATIONAL INSURANCE PLAN FOR THE SPECIFIED PERIOD. **IF AT ANY TIME YOUR HEALTH INSURANCE ENDS THAT WAS SUBMITTED ON YOUR WAIVER, YOU ARE RESPONSIBLE TO REACH OUT TO THE UB STUDENT HEALTH INSURANCE OFFICE TO BE COMPLIANT WITH YOUR VISA REQUIREMENTS.**

APPLICANT'S SIGNATURE DATE: ____/____/____