University at Buffalo
Student Health Insurance
Student Life

ENROLLMENT FORM FOR MEDICAL EVACUATION INSURANCE

Academic Policy Year: 2021-2022

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: 1CAPEN SUNY AT BUFFALO, BUFFALO, NY 14260 PH: (716) 645-3036 E-MAIL: ASKSHI@BUFFALO.EDU

PLEASE CHECK YOUR STATUS:

☐ INTERNATIONAL SCHOLAR	☐ FACULTY/STAFF TRAVELLING ABROAD

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

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

(____) _____ - _____ _____ _____ _____ _____
U.S. TELEPHONE EMAIL ADDRESS UB DEPT OR PROGRAM HOME COUNTRY VISA TYPE

___ ___ ___ ___ - ___ ___ ___ ___
UB PERSON NUMBER ○ MALE ○ FEMALE

Insurance periods cover from the 15th of one month to the 14th of the next month. For example, if you want coverage from Feb. 1 to Mar. 10, you would have to pay for two whole months (enrolling 15th January through 14th March). There are no exceptions without prior approval of the insurance office.

DATES OF COVERAGE : FROM _____/ 15 /_____ TO _____/ 14 /_____

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/21 - 1/14/22			
8/15/21 - 8/14/22	**OR SPRING**	1/15/22 - 8/14/22	5/15/22 - 8/14/22	X/15/XX - X/14/XX
	1/15/22 - 6/14/22			
$90.00	**$37.50**	**$52.50**	**$22.50**	**$7.50**

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 TO THE EMAIL ADDRESS PROVIDED.

I wish to enroll on the SUNY sponsored medical evacuation and repatriation program 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 decline the option of waiving off the SUNY sponsored Medical Evacuation and Repatriation coverage for the above-specified dates.

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

==========

FOR OFFICE USE ONLY:

Payment Reference #: _____ Payment Date: _____ Payment amount $: _____ Received by: _____

Effective Date: _____/_____/_____ Expiration Date: _____/_____/_____ Class: 8

OSA: _____ UHC: _____ Database: _____