

SUNY INTERNATIONAL STUDENT HEALTH INSURANCE

Return to Home Country Insurance Waiver Petition 2024 - 2025

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 Health Insurance office.

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

If an international student from SUNY at Buffalo is registered for one or more academic credit hours in a given semester during which he or she will be residing in his or her country of origin, that student may be eligible to waive the mandatory SUNY international health insurance requirement. The basis of the return trip must be academic (e.g. a student returning home to write his or her dissertation) and the student must intend to remain outside of the United States for the entire waiver period. If these qualifications are met, the student may proceed with the waiver process by completing and signing the form below and submitting it to their academic department. The completed form, signed by both the student and endorsed by the department, must then be submitted to the Student Health Insurance Office in 1Capen.

STUDENT PETITION INFORMATION

Name: _____ UB Person Number: _____
Family Name Given Name M.I.

E-Mail Address: _____ Citizenship: _____

Departure Dates from the U.S.: _____ / _____ / _____ Return Date to U.S.: _____ / _____ / _____
Month Day Year Month Day Year

Requested Waiver Period:

Semester (ex. Fall 2024) _____ (or) Academic Year (ex. 2024-2025) _____

I, THE UNDERSIGNED, VERIFY THAT ALL THE INFORMATION SUPPLIED ABOVE IS ACCURATE AND TRUTHFUL. I ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH 14 AUGUST 2025 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2025-2026 ACADEMIC YEAR. I ALSO FULLY AGREE TO HOLD HARMLESS THE STATE UNIVERSITY OF NEW YORK, THE UNIVERSITY AT BUFFALO AND ALL AGENTS AND AGENCIES OF THE AFORESAID ORGANIZATIONS, FOR ANY MEDICAL EXPENSES I MAY INCUR DUE TO LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT MEDICAL INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AND/OR DENY ANY REQUEST FOR WAIVER AT THEIR DESCRETION. **I UNDERSTAND THAT IF I RETURN TO THE UNITED STATES THAT I WILL HAVE A REQUIREMENT FOR HEALTH INSURANCE.**

Signature of Petitioner

_____/_____/_____
Month Day Year

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FOR OFFICE USE ONLY:

Date Received: _____ / _____ / _____

Processed By: _____