INTERNATIONAL HEALTH INSURANCE WAIVER FORM--SACM

(This waiver form is for SUNY at Buffalo international students only.)

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: ASKSMI@BUFFALO.EDU

PLEASE PRINT CLEARLY AND CAREFULLY READ THE FOLLOWING STIPULATIONS:

1.) **Partial and/or incomplete waivers will not be processed** and the applicant may be subject to late fees from the Student Health Insurance Office and/or the UB Bursars Office. Communication requesting further information will be directed to the e-mail address supplied by the applicant below.
2.) **Any student presenting a privately held insurance policy for waiver must provide a Clarification of Benefits form, completed by the insurance company or Human Resources, in order to determine the comparability of the private policy to SUNY's requirements. A copy of your insurance ID card must be submitted with the wavier.**
3.) **Submission Deadline for FALL 2020 OCTOBER 7, 2020**

APPLICANTS MUST COMPLETE ALL FIELDS:

_____ _____ _____ DATE OF BIRTH: _____/_____/_____
FAMILY NAME GIVEN NAME MI Mo. Day Year

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

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

___ ___ ___ ___ - ___ ___ ___ ___ _____
UB PERSON VISA TYPE ○ MALE ○ FEMALE

NAME OF COMPANY/AGENCY ISSUING YOUR POLICY:_____

HAVE YOU WAIVED UB'S INSURANCE IN A PREVIOUS YEAR WITH THIS SAME POLICY? ○ YES or ○ NO

ARE YOU A STUDENT COVERED BY A SPONSORING AGENCY (FULBRIGHT, YOUR EMBASSY, ETC.)? ○ YES _____ or ○ NO
SPECIFY

I UNDERSTAND THAT A WAIVER MAY ONLY BE PROCESSED IF MY PRIVATE INSURANCE IS COMPARABLE TO EVERY POLICY ITEM MANDATED BY THE STATE UNIVERSITY OF NEW YORK. I ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH 14 AUGUST 2020 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2020-2021 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 USE THE PHARMACY IN MICHAEL HALL AND HAVE THE CHARGES BILLED TO THE INTERNATIONAL INSURANCE PLAN, I WILL BE CHARGED RETROACTIVELY FOR THE FULL HEALTH INSURANCE PREMIUM WITHOUT POSSIBILITY OF WAIVER.**

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

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FOR OFFICE USE ONLY:

DATE PROCESSED _____/_____/_____

○ Accepted ○ Accepted with Medical Evacuation ○ Denied
○ Letter of notification ○ Letter of notification

OSA_____ UHCSR_____