ENROLLMENT FORM FOR INTERNATIONAL STUDENT HEALTH INSURANCE
Academic Policy Year: 2020-2021

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: ASKSMI@BUFFALO.EDU

PLEASE CIRCLE STATUS:

International Student in USA 1	**International Scholar in USA** 2	**International Student on Practical Training** (must provide copy of EAD card) 3

_____ _____ ____ DATE OF BIRTH: _____ / _____ / _____
FAMILY NAME GIVEN 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 or ○ 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
	8/15/20 - 1/14/21 **- $750.45**			
8/15/20-8/14/21	**SPRING**	1/15/21 - 8/14/21	5/15/21 - 8/14/21	X/15/XX - X/14/XX
	1/15/21- 6/14/21 **- $740.45**			
$1,792.28		**$1,041.83**	**$450.07**	**$149.69**

ALL UB STUDENTS MUST HAVE STUDENT ACCOUNT BILLED FOR THE HEALTH INSURANCE. DEPARTMENTAL INVOICES ARE AVAILABLE WITH PRIOR APPROVAL FROM THE HEALTH INSURANCE OFFICE. SMI OFFICE DOES NOT ACCEPT CASH OR CHECKS.

I wish to enroll in the SUNY International Health Insurance 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 of the international insurance plan for the specified period.

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

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FOR OFFICE USE ONLY:

E-Payment Date: _____ Payment amount $: _____ Received by: _____

Effective Date _____/_____/_____ Expiration Date _____/_____/_____ Class: ____

OSA: _____ United: _____ Previously GSEU / RF? YES NO

Database Update: _____