University at Buffalo
Student Health Insurance
Student Life

STUDENT

INTERNATIONAL HEALTH INSURANCE ENROLLMENT FORM 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 Student Health Insurance office.

PLEASE SUBMIT TO: ASKSHI@BUFFALO.EDU

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

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

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

_____ ○ MALE ○ FEMALE (Gender assigned at birth)
UB PERSON NUMBER

SELECT COVERAGE PERIOD:

○	**Fall** 8/15/2024- 1/14/2025	**$1,066.67**
○	**Spring/Summer** 1/15/2025- 8/14/2025	**$1,478.01**

ALL UB STUDENTS MUST HAVE STUDENT ACCOUNT BILLED FOR THE HEALTH INSURANCE. DEPARTMENTAL INVOICES ARE AVAILABLE WITH PRIOR APPROVAL FROM THE HEALTH INSURANCE OFFICE. THE PRICING LISTED IS EFFECTIVE FOR THE 2024-2025 POLICY YEAR UNTIL AUGUST 14, 2025.

***ENROLLMENT GUIDELINES: FOR APPLICATIONS RECEIVED AND ACCEPTED AFTER THE EFFECTIVE DATE OF THE POLICY PERIOD, BUT BEFORE THE ESTABLISHED DEADLINE FALL 9/27/24 OR SPRING 2/28/25, COVERAGE WILL BE EFFECTIVE THE FIRST DATE OF THAT POLICY PERIOD. APPLICATIONS RECEIVED AFTER THE DEADLINE WILL NOT BE ACCEPTED, UNLESS THERE IS A SIGNIFICANT LIFE CHANGE THAT DIRECTLY AFFECTS APPLICANT'S INSURANCE COVERAGE. APPLICATION TO ENROLL OFF CYCLE IN THE PLAN MUST BE MADE WITHIN 30 DAYS OF LOSS OF PRIOR COVERAGE. A LETTER OF CREDITABLE COVERAGE FROM THE PRIOR INSURANCE CARRIER MUST ACCOMPANY THE APPLICATION. POLICY REQUIREMENT FOR ENROLLMENT; REGISTERED WITH A MINIMUM OF 1 CREDIT HOUR .**

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.

_____ DATE: ____/____/____
SIGNATURE MONTH DAY YEAR

Student Health Insurance
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716.645-3036
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