

SUNY INTERNATIONAL STUDENT HEALTH INSURANCE

International On-Line Only Waiver Petition 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: 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 student must remain outside of the United States for the entire waiver period. If qualified, the student may proceed with the waiver process by completing and signing the form below. The completed form must then be emailed 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 the U.S.: _____ / _____ / _____
MONTH DAY YEAR MONTH DAY YEAR

Requested Waiver Period:

Semester (ex. Fall 2020) _____ (or) Academic Year (ex. 2020-2021) _____

IF I AM BILLED FOR THE INTERNATIONAL STUDENT HEALTH INSURANCE, IT IS MY RESPONSIBILITY TO REACH OUT TO THE STUDENT HEALTH INSURANCE OFFICE TO VERIFY THE STATUS OF THE REQUESTED WAIVER.

INITIAL HERE THAT YOU UNDERSTAND THE ABOVE STATEMENT. _____

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 2021 AND THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE 2021-2022 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 HEALTH INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AND/OR DENY ANY REQUEST FOR WAIVER AT THEIR DISCRETION. **I UNDERSTAND THAT IF I RETURN TO THE UNITED STATES THAT I WILL HAVE A REQUIREMENT FOR HEALTH INSURANCE.**

SIGNATURE OF STUDENT MONTH DAY YEAR

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FOR OFFICE USE ONLY:

Date Received: _____ Processed By: _____