INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM

This waiver is for international J-1 scholars and their J-2 dependents 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 Buffalo-North Campus, Buffalo, NY 14260 Ph: (716)645-3036 E-Mail: ASKSH@Buffalo.edu

APPLICANT MUST PRINT & COMPLETE ALL FIELDS.

ALL WAIVERS MUST BE ACCOMPANIED BY PROOF OF ENROLLMENT. A photocopy of the private insurance card or a certification of coverage in English from the scholar’s home university or employer are acceptable as proof of enrollment.

Scholars attempting to waive SUNY’s health insurance with a foreign insurer will be required to have a Clarification of Benefits form completed. The Clarification of Benefits must be signed completed by the private insurance company in order for the form to be accepted. The completed form must be signed by the scholar, returned to the UB Student Health Insurance Office before a determination can be reached as to the scholar’s eligibility for waiver.

As per U.S. Immigration & SUNY requirements, each visiting J-1 Scholar (along with any and all J-2 Dependents) must contract sufficient health insurance or show proof of sufficient private insurance to the UB Student Health Insurance Office within 31 days of entering the United States. This is a Visa proviso for all J-Visa holders and failure to comply will put the scholar’s (and dependent’s if applicable) Visa status in jeopardy.

____________________________________________________

DATE PROCESSED _____/_____/_____
SUNY-SHII Agent: ________

PharmLab/ ISSS Roster: ____________
Med. Evac. Enrollment: ____________

FOR OFFICE USE ONLY:

O Accepted Fully Comparable
O Accepted with Medical Evacuation
O Denied Waiver
O E-mail of Notification

Please submit to 1CAPEN, SUNY Buffalo-North Campus, Buffalo, NY 14260 Ph: (716)645-3036 E-Mail: ASKSH@Buffalo.edu
SUPPLEMENTAL CLARIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company or Human Resources. If the insurance company will not fill in the form, they may answer all questions on company letterhead. All monetary units must be expressed in U.S. Dollars.

You must sign the acknowledgement at the bottom of the form.

Student Name: ____________________________ Person number: ____________

Last Name First Name MI

Insurance Company Name: ____________________________ Policy Number: ____________________________

1. Effective dates of coverage

   /   /   Through   /   /

2. Total maximum benefit amount

   $

3. Are pre-existing conditions covered?

   YES    NO

4. Does plan directly pay benefits to providers in the USA?

   YES    NO

5. Is medical evacuation covered? To what amount?

   YES

   $  NO

6. Is repatriation covered? To what amount?

   YES

   $  NO

7. Maximum daily benefit for in-hospital room & board

   $

8. Are outpatient emotional and mental disorders covered?

   YES

   $  NO

   To what amount?

9. Are inpatient emotional and mental disorders covered?

   YES

   $  NO

   To what amount?

10. Is outpatient alcoholism and substance abuse covered?

    YES

    $  NO

   To what amount?

11. Are prescription drugs covered?

    YES

    NO

12. Are x-rays and lab work covered?

    YES

    NO

13. Are ambulance charges and medical equipment rental expenses covered?

    YES

    NO

Insurance/HR Representative Name

Insurance/HR Representative Signature

Phone

Date

I affirm all of the supplied information above is truthful. I take full responsibility for the answers I have supplied above, and fully agree to hold harmless the University at Buffalo for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give permission for enrollment and benefit information to be released to the Student medical Insurance Office at the University at Buffalo for the purpose of attempting an insurance waiver and to file for statistical use and use of the participant for medical reasons.

Policy Holder Signature

Date

Policy Holder's Email Address