University at Buffalo
Student Health Insurance
Student Life

SCHOLAR HEALTH INSURANCE WAIVER FORM 2024-2025

FOR INTERNATIONAL J-1 SCHOLARS AND 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.

UB EMPLOYEES WITH THE EMPLOYEE HEALTH INSURANCE NEED ONLY TO COMPLETE THE FIRST PAGE OF THE WAIVER PACKET AND PROVIDE LETTER FROM UB HUMAN RESOURCES STATING WHEN THE HEALTH INSURANCE ACTIVE. ANY SCHOLAR WITH HEALTH INSURANCE FROM OUTSIDE OF UB MUST HAVE THE CLARIFICATION OF BENEFITS PAGE COMPLETED BY THEIR INSURANCE COMPANY. ALL SCHOLARS ARE REQUIRED TO PURCHASE THE MEDICAL EVACUATION AND REPATRIATION INSURANCE ONCE YOUR WAIVER IS APPROVED.

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
UB PERSON NUMBER

NAME OF INSURANCE COMPANY: _____

ARE YOU COVERED BY A SPONSORING AGENCY (EX. EMBASSY, ETC.)? ○ YES _____ ○ NO
PLEASE SPECIFY

DEPENDENTS: _____
(NAME & DATE OF BIRTH)

_____

I UNDERSTAND THAT A WAIVER MAY ONLY BE PROCESSED IF MY CURRENT HEALTH INSURANCE IS COMPARABLE TO EVERY POLICY ITEM MANDATED BY THE STATE OF NEW YORK AND U.S. IMMIGRATION SERVICES FOR MY VISA STATUS. I UNDERSTAND THAT IF MY PRIVATE INSURANCE ENDS AT ANY TIME, IT IS MY RESPONSIBILITY TO CONTACT THE STUDENT HEALTH INSURANCE OFFICE TO ENSURE THERE IS NO GAP IN MY INSURANCE COVERAGE.

THIS WAIVER IS EFFECTIVE ONLY THROUGH THE END OF THE CURRENT ACADEMIC YEAR ON THE 14TH OF AUGUST. THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE NEXT ACADEMIC YEAR IN AUGUST IF I PLAN TO REMAIN IN THE UNITED STATES AS A VISITING SCHOLAR (OR DEPENDENT OF SCHOLAR) WITH SUNY AT BUFFALO. I ALSO FULLY AGREE TO HOLD HARMLESS SUNY, THE UNIVERSITY AT BUFFALO FOR ANY AND ALL MEDICAL EXPENSES I MAY INCUR DUE TO THE LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT HEALTH INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AS WELL AS DENY AND/OR REVOKE ANY WAIVER AT THEIR DISCRETION.

_____ DATE: ____/____/____
APPLICANT'S SIGNATURE MONTH DAY YEAR

Student Health Insurance
1 Capen, Box 28 North Campus, Buffalo, NY 14228
716.645-3036
askshi@buffalo.edu
buffalo.edu

○ ACCEPTED WITH MEDICAL EVACUATION PROCESSED BY: _____
ENROLLMENT DATES: _____
*INCLUDES DEPENDENTS LISTED ABOVE

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 THE QUESTIONS ON THE COMPANY LETTERHEAD. ALL MONETARY UNITS MUST BE EXPRESSED IN U.S. DOLLARS. THE SCHOLAR MUST SIGN THE ACKNOWLEDGEMENT AT THE BOTTOM OF THE FORM.

SCHOLAR NAME: _____ UB PERSON NUMBER: _____

INSURANCE COMPANY: _____ 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 AND BOARD: $_____
8. ARE OUTPATIENT EMOTIONAL AND MENTAL DISORDERS COVERED? TO WHAT AMOUNT? YES $_____ NO
9. ARE INPATIENT EMOTIONAL AND MENTAL DISORDERS COVERED? TO WHAT AMOUNT? YES $_____ NO
10. IS OUTPATIENT ALCOHOLISM AND SUBSTANCE ABUSE COVERED? TO WHAT AMOUNT? YES $_____ NO
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
14. IS THE POLICY AN ESSENTIAL OR COMMUNITY PLAN? YES NO

_____

(PRINT) 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 HEALTH INSURANCE OFFICE AT THE UNIVERSITY AT BUFFALO FOR THE PURPOSE OF ATTEMPTING AN INSURANCE WAIVER.

_____

(PRINT) SCHOLAR NAME SCHOLAR SIGNATURE DATE