

# 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: ASKSMI@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.

\_\_\_\_\_ FAMILY NAME \_\_\_\_\_ GIVEN NAME \_\_\_\_\_ MI \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

\_\_\_\_\_ U.S. MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ CODE \_\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_ U.S. TELEPHONE NUMBER \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_ UB DEPARTMENT / PROGRAM \_\_\_\_\_ HOME COUNTRY \_\_\_\_\_

\_\_\_\_-\_\_\_\_-\_\_\_\_ UB PERSON NUMBER \_\_\_\_\_ VISA STATUS \_\_\_\_\_  MALE  FEMALE

NAME OF INSURANCE COMPANY ISSUING YOUR POLICY: \_\_\_\_\_

HAVE YOU WAIVED UB'S INSURANCE IN A PREVIOUSLY WITH THIS SAME POLICY?  YES or  NO

ARE YOU COVERED BY A SPONSORING AGENCY (E.G. FULBRIGHT, YOUR EMBASSY, ETC.R)?  YES \_\_\_\_\_ or  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 ALSO UNDERSTAND THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH THE END OF THE CURRENT ACADEMIC YEAR—ACADEMIC YEARS END ON 14<sup>TH</sup> AUGUST. THUS, I MUST SUBMIT ANOTHER WAIVER FOR THE NEXT ACADEMIC YEAR DURING THE MONTH OF JULY OR 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 DESCRETION. I UNDERSTAND THAT IF I USE THE PHARMACY IN MICHAEL HALL ON THE UB SOUTH CAMPUS AND HAVE THE CHARGES BILLED TO THE SUNY INTERNATIONAL INSURANCE PLAN, I WILL BE CHARGED RETROACTIVELY FOR THE FULL HEALTH INSURANCE PREMIUM FROM THE POINT OF MY USEAGE.**

\_\_\_\_\_ APPLICANT'S SIGNATURE \_\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

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**FOR OFFICE USE ONLY:** DATE PROCESSED \_\_\_\_/\_\_\_\_/\_\_\_\_ SUNY-SHI Agent: \_\_\_\_\_

Accepted Fully Comparable  Accepted with Medical Evacuation  Denied Waiver

E-mail of Notification

Pharm/Lab/ ISSS Roster: \_\_\_\_\_ Med. Evac. Enrollment: \_\_\_\_\_

**INSURANCE COMPANY/HR REPRESENTATIVE:**  
Please return this form to the Student/Scholar ASAP

### 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