ENROLLMENT FORM FOR INTERNATIONAL HEALTH INSURANCE
Academic Policy Year: 2021-2022

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: AskSHI@BUFFALO.EDU

PLEASE CHECK STATUS:

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Student in USA</td>
<td>1</td>
</tr>
<tr>
<td>International Scholar in USA</td>
<td>2</td>
</tr>
<tr>
<td>International Student on Practical Training (must provide copy of EAD card)</td>
<td>3</td>
</tr>
</tbody>
</table>

LAST NAME                FIRST NAME          MI                         Mo.      Day     Year
_______________________________   ________________ _________________________    ____

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

U.S. TELEPHONE                 EMAIL ADDRESS                        UB DEPT OR PROGRAM           HOME COUNTRY             VISA TYPE

UB PERSON NUMBER

MALE    or    FEMALE

Insurance periods cover from the 15th of one month to the 14th of the next month. For example, if you want coverage from Feb. 1 to Mar. 10, you would have to pay for two whole months (enrolling 15th January through 14th March). There are no exceptions without prior approval of the insurance office.

DATES OF COVERAGE : FROM _____ / 15 / _____ TO _____ / 14 / _____

ALL UB STUDENTS MUST HAVE STUDENT ACCOUNT BILLED FOR THE HEALTH INSURANCE. DEPARTMENTAL INVOICES ARE AVAILABLE WITH PRIOR APPROVAL FROM THE HEALTH INSURANCE OFFICE. SHI OFFICE DOES NOT ACCEPT CASH OR CHECKS. ALL STUDENTS ON F-1 OPT AND J-1 SCHOLARS WILL RECEIVE A PAYMENT TO THE EMAIL ADDRESS PROVIDED.

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.

APPLICANT’S SIGNATURE           TODAY’S DATE: ____ / ____ / _____

====================================================================================================================
FOR OFFICE USE ONLY:

Payment Reference #: _____    Payment Date: _______    Payment amount $: _______    Received by: _______

Effective Date _____ / _____ / _____    Expiration Date _____ / _____ / _____    Class: _____

OSA: _______    United: _______    Previously GSEU / RF?    YES    NO

Database Update: _______