

# INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM

**THIS WAIVER IS FOR INTERNATIONAL J-1 SCHOLARS AND THEIR J-2 DEPENDENTS ONLY!**

PLEASE RETURN TO: **1CAPEN**, SUNY AT 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 medical 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 Medical 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 medical insurance or show proof of sufficient private insurance to the UB Student Medical 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 OF BIRTH: ____/____/____	
LAST NAME	FIRST NAME	MI	Mo.	Day Year
_____		_____	_____	_____
U.S. MAILING ADDRESS		CITY	STATE	ZIP CODE
(____) _____	_____	_____	_____	
U.S. TELEPHONE NUMBER	E-MAIL ADDRESS	UB DEPARTMENT / PROGRAM	HOME COUNTRY	
_____	_____	_____	_____	
UB PERSON NUMBER	VISA STATUS	<input type="radio"/> MALE or <input type="radio"/> 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.) ?  YES \_\_\_\_\_ or  NO  
PLEASE SPECIFY

**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 AND SUB-BOARD I, INC. FOR ANY AND ALL MEDICAL EXPENSES I MAY INCUR DUE TO THE LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT MEDICAL INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AS WELL AS DENY AND/OR REVOKE ANY WAIVER AT THEIR DISCRETION. 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 MEDICAL INSURANCE PREMIUM FROM THE POINT OF MY USAGE.**

\_\_\_\_\_  
APPLICANT'S SIGNATURE

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

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**FOR OFFICE USE ONLY:**

DATE PROCESSED ____/____/____	SUNY-SMI Agent: _____
<input type="radio"/> Accepted Fully Comparable	<input type="radio"/> Accepted with MedEvac
	<input type="radio"/> Denied Waiver
	<input type="radio"/> E-mail of Notification

Pharm/Lab/ ISSS Roster: \_\_\_\_\_ GB Enrollment: \_\_\_\_\_