ENROLLMENT FORM FOR STUDY ABROAD HEALTH INSURANCE

Academic Policy Year: 2017-2018

PLEASE RETURN TO: SMI OFFICE
PH: (716) 645-3036 / PDF E-MAIL: ASKSMI@BUFFALO.EDU

Destination of Domestic Student/Faculty Abroad: _____

UB Faculty Advisor for Program Abroad: _____ Advisor E-mail: _____

_____ _____ ____ DATE OF BIRTH: _____ / _____ / _____
LAST NAME FIRST NAME MI Mo. Day Year

_____ _____ _____ _____ _____
PREFERRED MAILING ADDRESS CITY STATE ZIP CODE

(_____) _____ - _____ _____ _____ _____
PREFERRED TELEPHONE E-MAIL ADDRESS UB DEPT OR PROGRAM HOME COUNTRY

__ __ __ __ - __ __ __ __
UB PERSON NUMBER O MALE or O FEMALE

CURRENT EDUCATIONAL LEVEL: (CIRCLE ONE) UNDERGRAD GRADUATE PROFESSIONAL FACULTY/STAFF/RESEARCH

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 / ____

Alternative Coverage Dates: FROM _____ / _____ / _____ TO _____ / _____ / _____
(Requires Prior Administrative Approval From SMI Office to Sponsoring Department—not optional to participant.)

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/16 - 1/14/17		5/15/17 - 8/14/17	
8/15/16-8/14/17	**OR SPRING**	1/15/17 - 8/14/17	**OR 3 MONTHS**	X/15/XX - X/14/XX
	1/15/17 - 6/14/17		X/15/XX - X/14/XX	
$627.72	$261.55	$366.17	$156.93	$52.31

Please indicate payment (circle one): **UB STUDENTS MUST HAVE THEIR STUDENT ACCOUNT BILLED.**

Cash, Check or Money Order Enclosed **Make check payable to SUNY at Buffalo**	Please Bill My Student Account (double check your person number above)	Please Invoice My Department (prior approval from insurance office required)

I wish to enroll on 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 the international insurance plan for my SUNY sponsored International Exchange or Study Abroad.

_____ TODAY'S DATE: ____ / ____ / ____
APPLICANT'S SIGNATURE Mo. Day Year

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FOR OFFICE USE ONLY:

Check number: _____ Receipt number: _____ Payment amount $: _____ Received by: _____

Effective Date _____/_____/_____ Expiration Date _____/_____/_____ Class: __5__

OSA: _____ HTH: _____ Previously GSEU / RF? YES NO

Roster Update: _____