

# ENROLLMENT FORM FOR INTERNATIONAL STUDENT HEALTH INSURANCE

**Academic Policy Year: 2016-2017**

*PLEASE RETURN TO: SUITE 315 STUDENT UNION, SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260  
PH: (716) 645-3036 / FAX: (716) 645-3465 / PDF E-MAIL: ASKSMI@BUFFALO.EDU*

PLEASE CIRCLE YOUR STATUS:

International Student in USA <span style="float: right;">1</span>	International Scholar in USA <span style="float: right;">2</span>	International Student on Practical Training (must attach practical training authorization papers) <span style="float: right;">3</span>
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\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 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

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

Insurance periods cover from the 15<sup>th</sup> of one month to the 14<sup>th</sup> 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 15<sup>th</sup> January through 14<sup>th</sup> March). There are no exceptions without prior approval of the insurance office.

<b>DATES OF COVERAGE :</b> FROM ____ / 15 / ____ TO ____ / 14 / ____
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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	<b>OR SPRING</b>	1/15/17 - 8/14/17	<b>OR 3 MONTHS</b>	X/15/XX - X/14/XX
	1/15/17 - 6/14/17		X/15/XX - X/14/XX	
\$1,302.00	\$542.50	\$759.50	\$325.50	\$108.50

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

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

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

FOR OFFICE USE ONLY:

Check number: \_\_\_\_\_ Receipt number: \_\_\_\_\_ Payment amount \$: \_\_\_\_\_ Received by: \_\_\_\_\_  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Class: \_\_\_\_  
 OSA: \_\_\_\_\_ HTH: \_\_\_\_\_ Previously GSEU / RF? YES NO  
 Roster Update: \_\_\_\_\_