

# INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM

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

**SEMESTER (CIRCLE ONE): FALL SPRING SUMMER**

PLEASE RETURN TO: SUITE 315 STUDENT UNION, SUNY AT BUFFALO – NORTH CAMPUS, BUFFALO, NY 14260  
PH: (716) 645-3036 – FAX: (716) 645-2465 – 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		
_____			_____		O MALE or O FEMALE			
UB PERSON NUMBER			VISA STATUS					

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 LAB OR 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.**

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

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<b>FOR OFFICE USE ONLY:</b>	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: \_\_\_\_\_ HTH Enrollment: \_\_\_\_\_

INSURANCE COMPANY:

Please return this form ASAP

By Fax: 716-645-3465

By Mail: University at Buffalo Medical Insurance, Suite 315 Student Union, Buffalo, NY 14260

By E-mail PDF: asksmi@buffalo.edu

CLARIFICATION OF INSURANCE POLICY BENEFITS - INBOUND INTERNATIONAL

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgement at the bottom of the form. All monetary units must be expressed in U.S. dollars.

Student Name: Last Name First Name MI Person number:

Insurance Company Name: Policy Number:

- 1. Effective dates of coverage / / Through / /
2. Total maximum benefit amount \$
3. Deductible Amount \$
4. Accidental Death Benefit \$
5. Didmemberment Benefit \$
6. Are pre-existing conditions covered? YES NO
Duration of possible waiting period? Months
\*Has it been met? YES NO
7. Is medical evacuation covered? YES NO
To what amount? \$
8. Is repatriation covered? YES NO
To what amount? \$
9. Maximum daily benefit for in-hospital room & board \$
10. Are outpatient emotional and mental disorders covered? YES NO
To what amount? \$
11. Are inpatient emotional and mental disorders covered? YES NO
To what amount? \$
12. Is outpatient alcoholism and substance abuse covered? YES NO
To what amount? \$
13. Are prescription drugs covered? YES NO Limit: \$
14. Are x-rays and lab work covered? YES NO Limit: \$
15. Are ambulance charges and medical equipment rental expenses covered? YES NO Limit: \$

Insurance Representative Name Insurance 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/Sub Board I, Inc. 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 SBI 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