ENROLLMENT FORM FOR STUDY ABROAD HEALTH INSURANCE

Academic Policy Year: 2016-2017 SEMESTER

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

Destination of Domestic Student/Faculty Abroad: ______________________________

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

______________ LAST NAME ______________ FIRST NAME _____ MI DATE OF BIRTH: _____ / _____ / _____ 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	
$527.50	$219.75	$307.50	$131.80	$43.95

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.

______________________________ APPLICANT'S SIGNATURE TODAY'S DATE: ____ / ____ / ____ 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: ______