INTERNATIONAL SCHOLAR HEALTH INSURANCE WAIVER FORM 2021-2022

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

The University at Buffalo is committed to ensuring equal access to information. As part of this commitment, university content must be accessible to everyone, including individuals with physical, sensory, or cognitive impairments, with or without the use of assistive technology. If you encounter an accessibility issue when completing this form, please contact the Student Health Insurance office.

PLEASE SUBMIT TO: 1CAPEN, SUNY Buffalo-North Campus, Buffalo, NY 14260 PH: (716)645-3036 E-Mail: ASKSHI@Buffalo.edu

APPLICANT MUST PRINT & COMPLETE ALL FIELDS.

ALL WAIVERS MUST BE ACCOMPANIED BY PROOF OF ENROLLMENT. A copy of your insurance card or certificate of coverage must be provided with the waiver. UB Employees with the employee health insurance need only to complete the first page of the waiver packet and provide letter from Human Resources stating when the health insurance began. Any scholar with health insurance from outside of UB must have the clarification of benefits page completed by insurance company. All scholars are required to purchase the medical evacuation and repatriation insurance once your waiver is approved.

As per U.S. Immigration & SUNY requirements, each visiting J-1 Scholar (along with any and all J-2 Dependents) must contract sufficient health insurance or show proof of sufficient private insurance to the UB Student Health 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 ○ MALE ○ FEMALE

NAME OF INSURANCE COMPANY: _____

ARE YOU COVERED BY A SPONSORING AGENCY (EX. EMBASSY, ETC.)? ○ YES _____ ○ NO
PLEASE SPECIFY

DEPENDENTS: _____
(NAME & DATE OF BIRTH)

_____

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 UNDERSTAND THAT IF MY PRIVATE INSURANCE ENDS AT ANY TIME, IT IS MY RESPONSIBILITY TO CONTACT THE STUDENT HEALTH INSURANCE OFFICE TO ENSURE THERE IS NO GAP IN MY INSURANCE COVERAGE. THIS WAIVER IS CONSIDERED EFFECTIVE ONLY THROUGH THE END OF THE CURRENT ACADEMIC YEAR—ACADEMIC YEARS END ON 14TH 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 FOR ANY AND ALL MEDICAL EXPENSES I MAY INCUR DUE TO THE LIMITATIONS OF MY PRIVATE HEALTH INSURANCE COVERAGE. THE UB STUDENT HEALTH INSURANCE OFFICE HAS THE RIGHT TO REQUEST ADDITIONAL INFORMATION AS WELL AS DENY AND/OR REVOKE ANY WAIVER AT THEIR DESCRETION. 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 HEALTH INSURANCE PREMIUM FROM THE POINT OF MY USEAGE.

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

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FOR OFFICE USE ONLY: DATE PROCESSED _____/_____/_____ SUNY-SHI Agent: _____

○ Accepted with Medical Evacuation ○ Denied Waiver

○ E-mail of Notification

Med. Evacuation Enrollment: _____

CLARIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company or Human Resources. If the insurance company will not fill in the form, they may answer all questions on company letterhead. All monetary units must be expressed in U.S. Dollars. You must sign the acknowledgement at the bottom of the form.

Student Name: _____ Person number: _____
Last Name First Name MI

Insurance Company Name: _____ Policy Number: _____

1. Effective dates of coverage ___/___/___ Through ___/___/___

2. Total maximum benefit amount $ _____

3. Are pre-existing conditions covered? YES NO

4. Does plan directly pay benefits to providers in the USA? YES NO

5. Is medical evacuation covered? To what amount? YES $ _____ NO

6. Is repatriation covered? To what amount? YES $ _____ NO

7. Maximum daily benefit for in-hospital room & board $ _____

8. Are outpatient emotional and mental disorders covered? YES $ _____ NO
To what amount?

9. Are inpatient emotional and mental disorders covered? YES $ _____ NO
To what amount?

10. Is outpatient alcholism and substance abuse covered? YES $ _____ NO
To what amount?

11. Are prescription drugs covered? YES NO

12. Are x-rays and lab work covered? YES NO

13. Are ambulance charges and medical equipment rental expenses covered? YES NO

14. Is the policy an Essential or Community plan? YES NO

_____ ___/___/___
Insurance/HR Representative Name Insurance/HR 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 for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give persmission for enrollment and benefit information to be released to the Student Health 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