University at Buffalo
Student Health Insurance
Student Life

# INTERNATIONAL HEALTH INSURANCE ENROLLMENT FORM 2023-2024
# SUMMER IDP PROGRAM

*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:** ASKSHI@BUFFALO.EDU

_____ DATE OF BIRTH: ____/____/____
LAST NAME FIRST NAME MI MONTH DAY YEAR

_____ _____ _____ _____
U.S. MAILING ADDRESS TOWN/CITY STATE ZIP CODE

(_____)_____-_____ _____ _____ _____
U.S. TELEPHONE EMAIL ADDRESS HOME COUNTRY VISA TYPE

_____ ○ MALE ○ FEMALE
UB PERSON NUMBER

## SELECT COVERAGE PERIOD:

| | | |
|---|---|---|
| ○ | **Summer**<br>5/15/24 – 8/14/24 | **$645.58** |
| ○ | **Monthly**<br>xx/15/24 – xx/14/24 | **$214.02** |

**ALL UB STUDENTS MUST HAVE STUDENT ACCOUNT BILLED FOR THE HEALTH INSURANCE. DEPARTMENTAL INVOICES ARE AVAILABLE WITH PRIOR APPROVAL FROM THE HEALTH INSURANCE OFFICE. THE PRICING LISTED IS EFFECTIVE FOR THE 2023-2024 POLICY YEAR UNTIL AUGUST 14, 2024.**

**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.**

_____ DATE: ____/____/____
APPLICANT'S SIGNATURE MONTH DAY YEAR

**Student Health Insurance**
1 Capen, Box 28 North Campus, Buffalo, NY 14228
716.645-3036
askshi@buffalo.edu
buffalo.edu

Student Account: _____ Processed by: _____ United: _____