University at Buffalo
Student Health Insurance
Student Life

Domestic Student Health Insurance Enrollment 2023-2024
United Healthcare Student Resources

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: STUDENT@HAYLOR.COM OR FAX: 315-362-5713 OR ASKSHI@BUFFALO.EDU

Student Name:Last: _____ First:_____

Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___ (Month / Day / Year) **Please circle one for claims processing:** MALE FEMALE (assigned at birth)

Phone Number: (_____) _____ - _____ **STUDENT ID NUMBER:** __ __ __ __ - __ __ __ __

E-Mail address : _____ **@BUFFALO.EDU**

2. List Dependents (Leave blank if not applicable)

	Last Name:	First Name	Date of Birth	Notes:	Required for Claims Processing (assigned at birth)
Spouse					M F
Child					M F
Child					M F
Child					M F

3. Select Enrollment Plan- PLEASE CIRCLE

Basic Plan	Annual Effective Date Aug. 1, 2023 July 31, 2024	Spring/Summer Effective Date Jan. 1, 2024 July 31, 2024	Summer Effective Date: May 1, 2024 July 31, 2024	Off Cycle Effective Date: _____/ 1 /_____ - July 31, 2024 Deadline: within 30 days
Student	$2,903.00	$1,689.45	$729.71	
Student + 1 Dependent	$5,806.00	$3,378.90	$1,459.42	
Student + 2 Dependents	$8,709.00	$5,068.35	$2,189.13	
Student + 3 or more Dependents	$11,612.00	$6,757.80	$2,918.84	

PLEASE COMPLETE AND SIGN THIS FORM.

4. Designate Payment Method: The premium will be billed and paid through your student account at the University at Buffalo.

5. Notice to Student (Signature required)

I have carefully read the policy plan provisions including all enrollment guidelines and elect to enroll as indicated above. **I permit UB to provide UnitedHealthcare StudentResources with enrollment status for purposes of eligibility under this plan**. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my dependents can be made void. I understand that if it is later determined that I am not eligible **(see the brochure, pamphlet or Master Policy for eligibility guidelines),** the premium will be refunded, but the premium is not refundable for reasons other than eligibility**.**

***Enrollment Guidelines: for applications received and accepted after the effective date of the policy period, but before the established deadline fall 9/29/23 or spring 2/23/24, coverage will be effective the first date of that policy period. Applications received after the deadline will not be accepted, unless there is a significant life change that directly affects applicant's insurance coverage. Application to enroll off cycle in the plan must be made within 30 days of loss of other coverage. A letter of creditable coverage from the prior insurance carrier must accompany the application.**

Policy Requirement for Enrollment; Matriculated with a minimum of 1 credit hour / Non-Matriculated minimum of 6 credit hours

Signature: _____ Date: _____