University of California, San Diego
Financial Aid Office, 9500 Gilman Drive Dept. 0013, La Jolla, CA 92093-0013
(858) 534-4480

BUDGET ADD-ON FOR DENTAL / MEDICAL / OPTICAL / INSURANCE EXPENSES

____________________________________ __________________ _____/_____

Student Name (Please Print) PID # Academic Yr.

Email __________________________ ☐ Undergraduate ☐ Graduate - Dept.__________________

A. Dental expenses for student and/or dependents of student:

1. Provide signature and cost estimate from a dental care representative in Part A (reverse side) of this form.
2. If you are a dependent student, obtain your parent's signature on Part D (reverse side) of this form.
3. Provide billings, receipts, cancelled checks or estimate signed by Provider (must be on Provider's letterhead).

B. Insurance expenses for dependents of student:

1. Provide a receipt or written estimate of the academic year insurance costs for the dependent(s). The estimate should be on the insurance company's letterhead.

C. Medical expenses for student and/or dependents of student: (including physicians, hospitals, lab work and pharmacy):

1. Provide verification from the Student Health Center regarding health insurance coverage, if any, and type of needs on Part B (reverse side) of this form.
2. If you are a dependent student, obtain your parent's signature on Part D (reverse side) of this form.
3. Provide receipts of expenses already incurred or written estimate of future expenses signed by Provider (must be on Provider's letterhead).

D. Optical expenses for student and/or dependents of student:

1. Provide billings, receipts, cancelled checks or estimate signed by Provider (must be on Provider's letterhead).
2. Part C (reverse side) must be completed by the Provider.
3. If you are a dependent student, obtain your parent's signature on Part D (reverse side) of this form.

I am requesting a budget add-on for the amount of $__________ to cover medical/dental/optical/insurance expenses not included in my standard UCSD student budget.

If approved, increased eligibility will be funded up to the maximum subsidized Stafford loan. Additional eligibility will be funded with unsubsidized Stafford loan and/or PLUS loan.

I certify that the information and documentation provided are complete and true to the best of my knowledge. I understand that expenses not documented will not be recognized.

You must submit Budget Add-On request no later than April 8th of the current academic year in order to receive Stafford/PLUS Loan.

________________________________ ________________

Student Signature Date

FAO OFFICE USE ONLY:
Total approved for add-on: $______________ FAO Counselor:__________________ Date:________________

(continued on next page)

BUDGET ADD-ON FOR DENTAL / MEDICAL / OPTICAL (cont'd)

TO: **UCSD - Financial Aid Office**
9500 Gilman Drive Dept. 0013
La Jolla, CA 92093-0013

FROM: ____
Name (please print)

____
Address

RE: ____
Student's Name

☐ **A. For Dental Needs**

$______________ minus $________________ = $_______________
Estimated Cost Amount paid by insurance Net Cost

☐ Dental treatment is necessary during this academic year for the general good health of the student, and is not deemed cosmetic in nature.

☐ Dental treatment can safely wait until after the student has completed this academic year and/or is deemed cosmetic in nature.

☐ Dental treatment needed is the result of an accident or other circumstance which can be covered with the student's health insurance, at no expense to the student.

☐ I estimate the cost for needed dental treatment to be (describe treatment/cost below):

____

____

______________________________________ ____________ ____________________
Signature of Dental Office/Insurance Representative Date Telephone Number

☐ **B. For Medical Coverage (through UCSD)**

☐ Student's needs are met by insurance with no expense to the student.

☐ Student's needs are not met completely by insurance. I estimate the cost to the student will be $_____________.

☐ Student does not currently have health insurance coverage for this need. I estimate the cost to the student will be $_____________.

______________________________________ ____________ ____________________
Signature of Health Insurance Rep./Student Health Date Telephone Number

☐ **C. For Optical needs:**

$______________ minus $________________ = $_______________
Estimated Cost Amount paid by insurance Net Cost

☐ Treatment is necessary during this academic year for the general good health of the student, and is not deemed cosmetic in nature.

______________________________________ ____________ ____________________
Provider's Signature/Title Date Telephone Number

☐ **D. Parental Statement for Dependent Students:**________________________________
(Parent's Name - please print)

Total treatment/expenses for my daughter/son cannot/will not be covered by my insurance carrier. I can contribute $_______________ toward her/his treatment/expense.

______________________________________ ____________
Parent's Signature Date