2020-2021 Cost of Attendance Add-On for
Medical / Dental / Optical / Insurance Expenses

RETURN This Form with the Requested Documentation to:
UC San Diego Financial Aid and Scholarships Office, MC 0013,
9500 Gilman Drive, La Jolla, CA
92093-0013, by fax to (858) 534-5459

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PRINT Student’s Last Name   First Name   Middle Initial   UC San Diego PID Number

☐ Undergraduate  ☐ Graduate - Department: _______________________

**Medical expenses for student and/or dependents of student:** (including physicians, hospitals, lab work and pharmacy):
1. Provide verification from the Student Health Center or Private Insurance Carrier regarding health insurance coverage, if any, and type of needs on Part A (page 2) of this form.
2. If you are a dependent student, obtain your parent’s signature on Part D (page 3) of this form.
3. Provide receipts of expenses already incurred or written estimate of future expenses signed by Provider, and on a Provider’s letterhead.

**Dental expenses for student and/or dependents of student:**
1. Provide signature and cost estimate from a dental care representative in Part B (page 2) of this form.
2. If you are a dependent student, obtain your parent’s signature on Part D (page 2) of this form.
3. Provide billings, receipts, cancelled checks or estimate signed by Provider, and on the Provider’s letterhead.

**Optical expenses for student and/or dependents of student:**
1. Provide billings, receipts, cancelled checks or estimate signed by Provider, and on Provider’s letterhead.
2. Part C (next page) must be completed by the Provider.
3. If you are a dependent student, obtain your parent’s signature on Part D (page 3) of this form.

**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 must be on the insurance company’s letterhead.

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I am requesting a Cost of Attendance Add-On for $__________ to cover medical/dental/optical/insurance expenses not covered by my insurance carrier and not included in my UC San Diego standard cost of attendance.

I understand the following:

1. The information and documentation provided by me are complete and true to the best of my knowledge.
2. That medical/dental/optical expenses I do not document will not be included and;
3. If I provide a printed itemized estimate, an unpaid billing statement, or other unpaid estimate for medical/dental/optical expenses, I may be selected in an audit; and will be asked to submit proof of my paid expenses by submitting a copy of the purchase receipt, cancelled check, or billing statement/invoice. **SAVE COPIES OF YOUR RECEIPTS**

Cost of Attendance Add-On requests must be submitted no later than May 15, 2021 of the current academic year to receive Direct Subsidized/Unsubsidized/PLUS Loans. **Submission of a request does not guarantee an approval.**

Student Signature ___________________________________________ Date ____________________________
2020-2021 COST OF ATTENDANCE ADD-ON FOR 
Medical / Dental / Optical / Insurance Expenses (cont’d)

A. UC San Diego PID Number

TO: UC San Diego - Financial Aid and Scholarships Office, MC 0013 
9500 Gilman Drive Dept. 0013 
La Jolla, CA 92093-0013

FROM: 
PRINT Company Name 
Address 

RE: 
PRINT Student’s First and Last Name 

☐ A. For Medical Coverage (through UC San Diego’s Student Health Services) 
☐ 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 Representative/Student Health _____________________________ 
Date ___________ 
Telephone Number ___________

☐ B. 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 or attached document)

__________________________________________________

Signature of Dental Office/Insurance Representative _____________________________ 
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 ___________
2020-2021 COST OF ATTENDANCE ADD-ON FOR Medical / Dental / Optical / Insurance Expenses (cont’d)

A ______________________________
Student’s UCSD PID Number

□ D. Parental Statement for Dependent Students:

PRINT Parent Name

Total treatment/expenses for my child cannot/will not be covered by my insurance carrier. I can contribute $____________ to toward my child’s treatment/expense.

Parent’s Signature _______________________________ Date __________ Telephone Number ____________________

FA OFFICE USE ONLY:
Total approved for add-on: $____________ FAS Counselor: ______________ Date: __________

☐ Former Foster Youth

COA Code on EU: BA (Cost of Attendance Add-On) – Refer to Cost of Attendance Add-On Instructions or Add-On Grid

Loan Period Received: ( ) Fall ( ) Winter ( ) Spring ( ) Summer Enter Memo data BUDxxxx, EFCxxxx, FAxxxx

Revised August 24, 2020