2015-2016 Budget Add-On for Medical / Dental / Optical / Insurance Expenses

RETURN THIS FORM TO: UCSD Financial Aid Office, 9500 Gilman Drive, La Jolla, CA  92093-0013

PRINT Student’s Last Name First Name Middle Initial UCSD PID Number

☐ Undergraduate ☐ Graduate - Dept._____________________

• 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 A (next page) of this form.
  2. If you are a dependent student, obtain your parent’s signature on Part D (next page) 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).

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

• 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 (next page) must be completed by the Provider.
  3. If you are a dependent student, obtain your parent’s signature on Part D (next page) 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 should be on the insurance company’s letterhead.

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 may be funded with grant aid (if funding is available). Additional eligibility will be funded with Direct Unsubsidized 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 requests no later than May 15th of the current academic year to receive Direct Subsidized/Unsubsidized/PLUS Loans. Submission of a request does not guarantee an approval.

________________________________________________________________________  ____________
Student Signature Date

FAO OFFICE USE ONLY:
Total approved for add-on: $__________ FAO Counselor: ______________________ Date: ________________

(continued on next page)
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 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 ____________

☐ 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):

    ____________________________________________________________
    ____________________________________________________________

    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 ____________

☐ 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 ____________