2018-2019 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

PRINT Student’s Last Name     First Name                Middle Initial     Student’s UCSD 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 (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 must be on the insurance company’s letterhead.

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 Wednesday, May 15, 2019 of the current academic year to receive Direct Subsidized/Unsubsidized/PLUS Loans. Submission of a request does not guarantee an approval.

_________________________   ____________________
Student Signature          Date
2018-2019 COST OF ATTENDANCE ADD-ON FOR
Medical / Dental / Optical / Insurance Expenses (cont’d)

A
Student’s UCSD 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):
   ____________________________________________________________________________

__________________________________________________________________________     ____________      ____________________________
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
# 2018-2019 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:**

<table>
<thead>
<tr>
<th>PRINT Parent Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total treatment/expenses for my daughter/son cannot/will not be covered by my insurance carrier. I can contribute $_______________ toward her/his treatment/expense.</td>
</tr>
<tr>
<td>Parent’s Signature</td>
</tr>
</tbody>
</table>

**FAS OFFICE USE ONLY:**

| Total approved for add-on: $_______________ | FAO 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 TU2 data BUDxxxx, EFCxxxx, FAxxxx