2019-2020 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

A

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, 2020 of the current academic year to receive Direct Subsidized/Unsubsidized/PLUS Loans. **Submission of a request does not guarantee an approval.**

___________________________________________   ____________________________
Student Signature                      Date

Revised June 11, 2019
2019-2020 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

________________________________________________     ___________  ____________________________
Signature of Health Insurance Representative/Student Health     Date                Telephone Number

□ 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 $_____________.

□ 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

FAO: rev Cost of Attendance Add-Ons
2019-2020 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
$____________________ toward my child’s treatment/expense.

________________________________________________   _____________     ________________
Parent’s Signature                                                                  Date                       Telephone Number

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

Revised June 11, 2019