

# 2011-12 SIGNIFICANT MEDICAL/DENTAL EXPENSES FORM

Student's Name \_\_\_\_\_ Reed ID # (if known) \_\_\_\_\_

By completing and submitting this form, you are requesting the Reed College Financial Aid Office to reevaluate your financial aid eligibility based on special circumstances. The Reed College Financial Aid Office reviews such requests on an individual basis and will respond in writing as to the results of this review. Please note the following:

- If consideration for these expenses is granted, it may be on a **one time only** basis.
- The expenses to be considered must be required treatment; elective, cosmetic, or optional treatment will not be considered.
- Additional documentation from a health care professional may be required.

## 1. COMPLETE THE FOLLOWING:

TYPE OF SERVICE	DATE OF SERVICE	AMOUNT <b>NOT</b> PAID BY INSURANCE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

(use additional page if necessary)

## 2. DOCUMENTATION

- Attach copies of bills for all expenses you are claiming
- Attach proof that the claim has not/will not be paid by insurance

## 3. READ AND SIGN

All of the information included with this form is true and complete to the best of my knowledge. I agree to provide additional documentation if requested.

\_\_\_\_\_  
Student Signature (if student information provided)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (if parent information provided)

\_\_\_\_\_  
Date

**Submit this form to the Office of Financial Aid, Reed College, 3203 SE Woodstock Blvd, Portland, OR 97202-8199.**