

Student's Name (Last, First, M.I.). PLEASE PRINT.

Student Identification Number (SID)

**Instructions**

Complete the following worksheet and provide documentation of medical expenses you paid or expect to pay in 2009 such as Explanation of Benefits (EOB) statements from your insurance provider, billing statements, or receipts from your health care provider (s).

For dependent students, report medical expenses paid by the parent(s) whose income is reported on the FAFSA. For independent students, report medical expenses paid by you and/or your spouse.

**Medical Expenses Paid in 2009**

<i>Date Service Was Received</i>	<i>Name of Medical Provider (doctor, , dentist, optometrist, hospital, pharmacy, health insurance premiums, etc.)</i>	<i>Total Cost of Service Received (if known)</i>	<i>Amount Not Covered by Insurance</i>	<i>Amount Paid in 2008</i>	<i>Date You Paid</i>	<i>Supporting Documents Attached? Y / N</i>
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TOTAL this page						

By signing this form, I certify that all the information provided is complete and accurate.

Student signature

Date

Parent signature (for Dependent students) or signature of student's spouse

Date

Please mail or fax this form to:

University of Colorado at Boulder  
Office of Financial Aid, ATTN: PJ  
77 UCB  
Boulder, CO 80309-0077  
FAX: 303-492-0838, ATTN: PJ