2017-2018 Request for Review
Due to Medical Expenses

Student Info:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>ID#</th>
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Street                  City                  State         Zip

<table>
<thead>
<tr>
<th>Phone #</th>
<th>Cell #</th>
<th>Preferred Email</th>
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Parent(s) Name(s)        Phone #        Preferred Email

|                     |         |                 |
|                     |         |                 |

Please complete and return this form and documentation (bills, statements, pharmacy reports, etc.) to the address above.

From January 1, 2017 to today, you have paid the following amount(s) in medical and/or dental expenses that are not covered by insurance or any public or private health care benefit. These expenses will not be reimbursed to you. This can include co-payments to a pharmacy. It would also be helpful if you could indicate whether a full payment has been made, or if you are making monthly payments to the provider.

$ _______________ Paid to ______________________________________________________

$ _______________ Paid to ______________________________________________________

$ _______________ Paid to ______________________________________________________

(Attach additional sheet(s) if needed.)

Do you have a Flex Medical Plan to help cover some of the medical expenses above that are not reimbursed?  
_____ Yes  _____ No
If so, what amount is contributed to this plan monthly? ________________________
How much has been withdrawn to date this year? ________________________________

I certify the above is true and accurate to the best of my ability at this time. I understand that I may be asked for further information and documentation.

_________________________________________  ________________________
Signature                                      Date

_________________________________________
Your relationship to Student