



Return to:
Office of Financial Aid
301 Platt Boulevard
Claremont, CA 91711
Office: (909) 621-8055
Fax: (909) 607-7046
financial_aid@hmc.edu

Name of Student Financial Aid Applicant (please print):

Last

First

Middle

Social Security Number: _____ - _____ - _____

**STUDENT (AND SPOUSE - if applicable)
 2007 MEDICAL/DENTAL EXPENSE FORM**

The Office of Financial Aid requires the following information to verify the medical/dental expenses you and/or your spouse reported on your 2008-2009 financial aid application.

Please list all out-of-pocket medical/dental expenses that you and/or your spouse paid in the year 2007. You may include the cost of medical/dental insurance premiums, but do NOT include any cost(s) reimbursed by insurance company(ies). **Attach documentation of paid medical and/or dental expenses to this form.**

<u>NAME OF PERSON/AGENCY PAID</u>	<u>DATE PAID</u>	<u>AMOUNT PAID</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
Total 2007 Medical/Dental Expenses		\$ _____

SIGNATURES: Student _____ Date _____
 Student's Spouse _____ Date _____
 (if applicable)