

# REQUEST FOR A REVIEW OF EMERGENCY OR EXTRAORDINARY EXPENSES DURING THE STUDY PERIOD



If you have experienced unavoidable or extraordinary expenses that make it impossible for you or your family to provide the expected contributions, please complete the following appropriate section(s). This form is being submitted for the following students:

Last Name	First Name	Social Insurance Number

**Emergency dental/medical/optical expenses** \$ \_\_\_\_\_

An emergency expense would usually be the result of an accident. It is not intended to include expenses that would have arisen in the ordinary course of the family's life. For example: orthodontic care, or the purchase of glasses or contact lenses would not be considered. Documentation required:

- Medical certificate or letter from dentist, physician, or ophthalmologist outlining the nature of the emergency care required; and
- Proof of the payment of the emergency care and that such costs were not covered by a health or insurance plan.

**Emergency home repairs** \$ \_\_\_\_\_

An emergency home repair would usually be the result of an unexpected destructive force such as a fire or flood. For example: roof damage because of weather conditions. These emergency expenses are not intended to include household repairs and home renovations that arise in the ordinary course of home ownership. Documentation required:

- Receipts for the repairs;
- Proof that the costs were not included in any type of warranty or insurance plan; and
- Attach a brief explanation of the expense and when it occurred.

**Extraordinary health care costs because a family member is ill** \$ \_\_\_\_\_

The health care costs would be those incurred because there is no alternative. For example: the costs associated with necessary inter-provincial or inter-city travel to a children's hospital or the cost of attendant care during convalescence. The costs incurred cannot be covered by any health or insurance plan. Documentation required:

- Medical certificate or letter from a physician outlining the nature of health care required; and
- Receipts for expenses incurred.

**Prescription costs (not fully covered by a drug or insurance plan)** \$ \_\_\_\_\_

Prescription costs can be considered because of a chronic or life-threatening illness you or a member of your family may have. For example: someone who is diabetic and requires insulin or someone with cystic fibrosis that needs costly drugs. Documentation required:

- Proof of the payment for the prescription drugs and that such costs were not included in a health or insurance plan.

**Declaration and Required Signatures**

The student and any person(s) claiming above-noted expenses must complete this section.

*I declare that the information provided on this form is accurate and complete. I understand that the information I/we have submitted is subject to verification and audit.*

Signature of Student

Date

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**For Dependent Students**

Signature of Parent/Step-Parent/Guardian

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**For Married/Common-law Students**

Signature of Partner

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