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|-------------------|--------------------|-----------------------|
| Student Last Name | Student First Name | Student Ben ID Number |

All **Sections I, II, & III** of this form must be completed in full and submitted simultaneously with all required documentation. Your appeal will be reviewed only when all required documentation has been received.

Do not leave any information blank. If the information does not pertain to you, indicate Non-Applicable (N/A).

SECTION I: REASON FOR REQUEST

Select the option below that best pertains to your appeal.

| Dependent Student | |
|--------------------------|---|
| <input type="checkbox"/> | My parent(s) and/or I paid medical, dental, nursing home or child care expenses in 2025 that exceeded 7.5% of the total household income earned in 2024 . |
| <input type="checkbox"/> | My parent(s) and/or I will have medical, dental, nursing home or child care expenses during the 2026-2027 academic year that <u>will not</u> be reimbursed by insurance. |

| Independent Student | |
|----------------------------|--|
| <input type="checkbox"/> | My spouse and/or I paid medical, dental, nursing home or child care expenses in 2025 that exceeded 7.5% of the total household income earned in 2024 . |
| <input type="checkbox"/> | My spouse and/or I will have medical, dental, nursing home or child care expenses during the 2026-2027 school year that <u>will not</u> be reimbursed by insurance. |

SECTION II: Extenuating Expenses

| Name of person who paid the extenuating expenses | Total out of pocket paid in 2025 | Total out of pocket estimate in 2026 |
|--|----------------------------------|--------------------------------------|
| | \$ | \$ |

- Signed copy of 2024 Federal Tax Return and all schedules, **Schedule A** must be included.
- Supporting documentation of expense not covered by insurance.
- A letter summarizing in detail condition, treatment and expenses.

Section III: Certification & Signature

I/We, hereby certify that all of the information that is provided on this form is true, complete and correct to the best of my/our knowledge. I understand that if corrections need to be made to my FAFSA results, the Office of Financial Aid will make all necessary corrections.

| Student's Signature Required | Date | Parent's (or spouse if applicable) Signature Required | Date |
|------------------------------|------|---|------|

Please submit the signed and completed form, along with supporting documentation, to the Office of Financial Aid via our dropbox located on our [website](#) or via email to financialaid@ben.edu.