

Request for Forbearance/Hardship/Unemployment Institutional Loan

I understand that all information and supporting documents given will be held in strictest confidence and will not be subject to dissemination outside the requirements of the lending institution. I further understand that if granted, this FORBEARANCE is for no more than six month's duration during which time interest will continue to accrue, if applicable.

If your loan is cosigned, your cosigner will also need to complete this form and qualify with required documentation.

Borrower's/Co-signer's Name/Address: _____

Return form to:

**Pepperdine University
Account Resolution Office
24255 Pacific Coast Highway
Malibu, CA 90263-4306
Fax # 310-506-7559**

This form is being completed by the borrower. Name: _____

This form is being completed by the Co-signer. Name: _____

Section 1. Forbearance Request

(Forbearance/ Hardship) – Interest continues to accrue if applicable. My interest payment will be billed to me monthly. I request forbearance/hardship on my loans because:

(A) _____ My loan payments are equal to or greater than 20% of my total monthly income. **(Complete sections 2 & 3)**

(B) _____ I am unable to make scheduled payments due to "Poor Health" (temporarily/totally disabled). **(Complete sections 2 & 4)**

(C) _____ I am in an approved **rehabilitation** training program for disabled individuals. **(Complete sections 2 & 4)**

(D) _____ Caring for a **dependent** who is disabled. **(Complete sections 2 & 4)**

(Unemployment Forbearance) I request unemployment forbearance. I am currently unemployed, actively seeking employment and registered with an employment agency. **(Complete sections 2 & 3)**

Section 2. Borrower or Co-signer Certification

I certify that all statements made are true and correct. I also certify that I will immediately notify the lending institution of any change in my employment status or significant change in my financial situation. I authorize a representative of the lending institution to obtain from my applicable parties' pertinent information in order to verify this application. Final responsibility for completion and return of this form to the institution rests with the borrower. This account will remain in status quo until this form is approved. Incomplete forms will be returned.

Signature _____ Date _____

Day Phone _____ Evening Phone _____ Cell phone _____

Marital Status _____ Dependents – Number _____ Age(s) _____

Please list the name, address, and phone number of someone who will always know your whereabouts:

Name: _____ E-mail: _____

Address: _____

Day Phone _____ Evening Phone _____ Cell phone _____

Section 3. Income and Expenses

My Monthly Income	My Monthly Expenses	Student Loan Information	
* _____ Gross Wages	*** _____ Housing	*** _____ SFA Loan PYMTS	Type Loan Amt Mthly Pmt
* _____ Spouse's	*** _____ Food	*** _____ Credit Card	_____ \$ _____ \$
** _____ Public Assistance	*** _____ Utilities	*** _____ Car Expenses	_____ \$ _____ \$
** _____ Unemployment	*** _____ Bank Loans	_____	_____ \$ _____ \$
** _____ Child Support	*** _____ Car Payment	_____	_____ \$ _____ \$
** _____ Other Income	*** _____ Medical – (NOT COVERED BY INSURANCE)	_____	_____ \$ _____ \$
** _____ Workmen Comp	*** _____ Phone	_____	_____ \$ _____ \$
\$ _____ Total \$	_____ Total	Total	\$ _____ \$ _____

Section 4. Statement of Disability (Completed by Physician)

Patient's Name: _____ Subjective symptoms: _____
 Relationship to Borrower: _____ Objective symptoms: _____
 Date when symptoms first appeared: _____ Diagnosis: _____
 Date accident occurred: _____ **If needed please attach a separate sheet of paper.**

Treatments

First visit date: _____ Last visit date: _____ Frequency of visit (Weekly, Monthly, Other) _____

Progress

Present condition: Recovered _____ Unchanged _____ Improved _____ Retrogressed _____
 Is patient: Ambulatory _____ Bed Confined _____ House confined _____ Hospital confined _____

Extent of Disability

Is patient 'NOW' totally disabled ?

If no, when is or was the patient able to go to work

Will patient be able to resume any work?

Indefinite

Never

Any Occupation		Regular Occupation	
YES _____	NO _____	YES _____	NO _____
MM/DD/YY _____		MM/DD/YY _____	
MM/DD/YY _____		MM/DD/YY _____	
YES _____	NO _____	YES _____	NO _____
YES _____	NO _____	YES _____	NO _____

If yes, is patient a suitable candidate for rehabilitation? Yes _____ No _____

Physician Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Date _____ Attending Physician Signature _____

Institutional Action

Date _____ - _____ Approved _____ Disapproved _____ Official _____ Date _____