

Request for Forbearance/Hardship/Unemployment Deferment

SECTIONS 1, 2, AND 3 MUST BE COMPLETED IN FULL

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 this arrangement will consist of reduced or deferred payments, as determined by the lending institution based on my financial situation. It may be necessary to make accelerated payments at the expiration of this arrangement to repay the loan within the maximum ten-year period.

Borrower's Name/Address:

Mail form to:
CUNY
C/O E.C.S.I.
PO BOX 15510
PITTSBURGH PA 15244

Email Address

Account Number:

LENDING INSTITUTION: F5-

Section 1 Applicable Benefits – Must be completed in full

Benefit types 1 and 2: Applicable to federal Perkins, Nursing/Health profession, and selected Institutional loans.
Benefit types 3 and 4: Applicable to Perkins loans.

- Benefit type 1 – I request forbearance on my Perkins loans because (Select one from A-D & check 1 or 2 on E):**
 (A) ___ My title IV SFA loan payments are equal to or greater than 20% of my total monthly income. **(Complete sections 2 and 3)**
 (B) ___ I am unable to make scheduled payments due to 'Poor Health' (temporarily – totally disabled). **(Complete sections 2 and 4)**
 (C) ___ Caring for a **dependent** who is disabled. **(Complete sections 2 and 4)**
 (D) ___ Interest continues to accrue during this benefit type. For interest payment (1) ___ bill me monthly (2) ___ bill me at end of my benefit.
(We recommend paying interest monthly to avoid a lump sum payment at the end of this benefit type or forbearance)

- Benefit type 2 – I request a Temporary reduction of my monthly loan payment:**
 Based on my financial situation, I will make monthly payments in the amount of \$ _____ for a period of _____ months. If approved, I agree to make repayment of this amount each month as a condition of this agreement, and that if payment is not made, my agreement may be terminated by the school. **(Complete sections 2 and 3)**

- Benefit type 3 – I request economic hardship deferment because:**
 (A) ___ I have been granted economic hardship for William D. Ford Federal Direct Student Loan (FDSL) or Federal Family Education Loan (FEEL) for the current period of time. **(Supporting documentation is required and "full completion of section 3")**
 (B) ___ I am receiving payment under Federal or State Public Assistance. (AFDC, Supplemental Security income, Food Stamps, or State Public Assistance). **("completion of sections 2 and 3 is required")**
 (C) ___ My title IV SFA loan payments are equal to or greater than 20% of my total monthly income, and my monthly gross income minus my Title IV loan payments is less than 220% of the earnings of individuals on minimum wage, or 100% of the poverty income for a family of two. **(Complete sections 2 and 3)**

- Benefit type 4 – I request an unemployment deferment for a period of _____ month(s).**
 1. I am currently unemployed and actively seeking employment. In order to verify that I am actively seeking employment, I must register with an employment agency and **have this form certified**
 2. Certification by employment agency:

I, _____, certify that the above-mentioned individual has been duly registered with this employment agency.

Agency Name _____ Address _____

City _____ State _____ Zip _____ Phone number _____

Section 2 Borrower Certification – Must be completed in full

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 if this form is incomplete; it will be returned to the borrower.

Signature _____ SS Number _____ 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 _____

Address _____

Day Phone _____ Evening Phone _____ Cell Phone _____

Institutional Action

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

Section 3 Income and Expenses – Must be completed in full

My Monthly Income

Student Loan Information

* _____ Gross Wages	Type	Loan Amt	Mthly Pmt
* _____ Spouse's	_____	\$ _____	\$ _____
** _____ Public Assistance	_____	\$ _____	\$ _____
** _____ Unemployment	_____	\$ _____	\$ _____
** _____ Child Support	_____	\$ _____	\$ _____
** _____ Other Income	_____	\$ _____	\$ _____
** _____ Workmen Comp	_____	\$ _____	\$ _____
\$ _____ Total	Total	\$ _____	\$ _____

*PLEASE FURNISH CHECK STUB **PLEASE FURNISH EVIDENCE

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**

Treatment

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

	Any Occupation	Regular Occupation
Is patient 'NOW' totally disabled for	YES _____ NO _____	YES _____ NO _____
If no, when is or was the patient able to go to work	MM/DD/YY _____	MM/DD/YY _____
Will patient be able to resume any work	MM/DD/YY _____	MM/DD/YY _____
Indefinite	YES _____ NO _____	YES _____ NO _____
Never	YES _____ NO _____	YES _____ NO _____

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

Physician Name _____ Physician License Number _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax number _____ Date _____

Attending Physician Signature _____