REQUEST FOR FORBEARANCE OR HARDSHIP: LAGER AND LYNCH LOANS ONLY

SETON HILL UNIVERSITY

I understand that all information and supporting documents will be held in strictest confidence and will not be subject to dissemination outside the requirements of the lending institution. I further acknowledge that this arrangement will consist of reduced or deferred payments, as determined by the lending institution based upon my financial situation. In addition, I understand that it may be necessary to make accelerated payments at the expiration of this arrangement to repay the loan within the maximum five-year repayment period.

Borrower's Name & Address:________________________

____

____

____

Mail Form to:

SETON HILL UNIVERSITY
PERKINS, LAGER, & LYNCH LOAN PROGRAMS
BUSINESS OFFICE BOX 992
ONE SETON HILL DRIVE
GREENSBURG PA 15601

Email Address: __________________________________

Lending Institution: ***SETON HILL UNIVERSITY***

Account Number (Social Security #):_______________

Section 1: Applicable Benefits

☐ **Benefit Type 1—FORBEARANCE: MAKE NO PAYMENTS OR INTEREST-ONLY PAYMENTS FOR SIX MONTHS. (YOU MAY ONLY RECEIVE THIS BENEFIT FOR TWELVE MONTHS MAXIMUM [I.E., TWO (2) SIX-MONTH FORBEARANCES] ON YOUR LAGER OR LYNCH LOAN EVER).**

I request a forbearance on my Lager or Lynch loan because:

(A) _____My monthly Title IV loan (Stafford and Perkins only) ***and/or my LAGER/LYNCH loan*** debt burden either equals or exceeds 20 percent of my total monthly gross income. (Complete sections 2 and 3).

(B) _____The Department of Education has authorized a period of forbearance for federal Perkins loans due to a national military mobilization or national emergency.

(C) _____ I am unable to make scheduled payments due to 'poor health.' (Complete sections 2 and 4)

(D) _____ I am unable to make scheduled payments due to unemployment. (Complete sections 2 and 3)

(E) _____ I am unable to make scheduled payments due to other acceptable reasons (Complete sections 2, 3 and /or 4 as necessary—attach additional sheets for explanation as needed).

(F) Interest accrues during this benefit. For interest payment, please (1) _____bill me monthly or (2) _____bill me at the end of my benefit (lump sum interest payment).

☐ **Benefit Type 2—HARDSHIP: REDUCED PAYMENTS FOR A PERIOD OF TIME LONGER THAN THE ORIGINAL FIVE-YEAR REPAYMENT PERIOD.**

Due to economic hardship,

(A) _____ I request an extension of my repayment period of _____ years (maximum five (5) additional years) because I qualify as a low-income individual during the repayment period. (Complete sections 2 and 3)

(B) _____ I request an extension beyond my original five-year repayment period because prolonged illness prevents me from making scheduled payments. (Complete sections 2 and 4)

(C) _____ I request an extension beyond my original five-year repayment period because unemployment prevents me from making scheduled payments. (Complete sections 2 and 3)

(D) Interest accrues during this benefit. For interest payment (1) _____bill me monthly or (2) _____ bill me at the end of my benefit (lump sum interest payment).

Section 2: Borrower 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; if this form is incomplete, it will be returned to the borrower.

Signature_____________________________ SS Number __________________ Date_____________

Day Phone ________________ Evening Phone ________________ Cell Phone _________________

Marital Status ___________Number of Dependents_____________ Age(s) _____________________

Please list the names, addresses, and phone numbers of <u>three</u> people who will always know your whereabouts:

Name____

Address____

____

Day Phone _______________ Evening Phone _______________ Cell Phone __________________

Name____

Address____

____

Day Phone _______________ Evening Phone _______________ Cell Phone __________________

Name____

Address____

____

Day Phone _______________ Evening Phone _______________ Cell Phone __________________

Section 3: Income and Expenses

BEFORE COMPLETING THIS SECTION, BE AWARE THAT THIS FORM WILL BE CONSIDERED INCOMPLETE UNLESS YOU PROVIDE THE FOLLOWING REQUIRED DOCUMENTATION:

1. **Pay Check stubs or other documentation as proof of any income you note below under "Monthly Income."**
2. **Bills, statements, or other documentation as proof of any income you note below under "Monthly Expenses."**

IMCOMPLETE FORMS WILL BE RETURNED TO YOU AND WILL DELAY THE PROCESSING OF ANY NEEDED FORBEARANCE OR HARDSHIP.

MONTHLY INCOME		**MONTHLY EXPENSES**		
My Monthly Income:		**My Monthly Expenses (include student loans):**		
*__________	Gross Wages	EXPENSE TYPE	IF LOAN, TOTAL AMOUNT OWED	MONTHLY PAYMENT
*__________	Spouse's Gross Wages	____________________	$____________	$______________
**__________	Public Assistance	____________________	$____________	$______________
**__________	Unemployment	____________________	$____________	$______________
**__________	Child Support	____________________	$____________	$______________
**__________	Other Income	____________________	$____________	$______________
$__________	Total	____________________	$____________	$______________
***PLEASE**	**FURNISH CHECK STUB**	____________________	$____________	$______________
		____________________	$____________	$______________
		____________________	$____________	$______________
		____________________	$____________	$______________
		____________________	$____________	$______________
		TOTAL	$____________	$______________

****PLEASE FURNISH EVIDENCE**

ATTACH ADDITIONAL SHEETS AS NECESSARY

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 happened________________________ **If needed, please attach a separate sheet of paper.**

Treatment

First Visit Date _________ **Last Visit Date**__________ **Frequency of Visits (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/YYYY**__________	**MM/DD/YYYY**__________
Will patient be able to resume any work?	**MM/DD/YYYY**__________	**MM/DD/YYYY**__________
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 Code**________________

Phone Number___________________________ **Fax Number**_____________________ **Date**_______________

Attending Physician Signature____

****(Please attach additional sheets for any comments.)****

Institutional Action—STAFF USE ONLY

Date__________ Approved__________ Disapproved___________ Official _________________________________