Forbearance

11/22/1999

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:

Educational Computer Systems, Inc.
181 Montour Run Road
Coraopolis, PA 15108

Account Number:

Section 1 Applicable Benefits

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:**
(A)___ My title IV SFA loan payments are equal to or greater than 20% of my total monthly income. (Complete section 2 and 3)
(B)___ I am unable to make scheduled payments due to 'Poor Health' (temporarily – totally disabled). (complete section 2 and 4)
(C)___ I am enrolled in a course of study that is part of Department approved **rehabilitation** training program for disabled individuals. (Complete sections 2 and 4)
(D)___ Caring for a **dependent** who is disabled. (Complete section 2 and 4)

☐ **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 section 2 and 3)

☐ **Benefit type 3 – I request economic hardship 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. **(Satisfactory documentation is required)**
(B)___ I am receiving payment under Federal or State Public Assistance. (AFDC, Supplemental Security income, Food Stamps, or State Public Assistance). (Complete section 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 duty registered with this employment agency.

Name_____ Address_____

City_____ State_____ Zip_____ Phone number_____

Section 2 Borrower Certification

I certify that all statements mad 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:

Signature_____ SS Number_____ Date_____

Day Phone_____ Evening Phone_____ Cell Phone_____

Marital Status_____ Dependents – Number_____ Age(s)_____

Institutional Action

Date_____ - _____ Approved_____Disapproved_____Official_____Date_____

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				
$_____0.00_____**Total**	$_____0.00_____**Total**		**Total**	$_____0	$_____0.00

***PLEASE FURNISH CHECK STUB** ****PLEASE FURNISH EVIDENCE** *****PLEASE FURNISH COPIES OF BILLS**

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_____ Address_____

City_____ State_____ Zip_____

Phone Number_____ Fax number_____

Date_____ Attending Physician Signature_____