Request for Hardship Forbearance/Disability Forbearance/Reduced Payment

Borrower Name: _____

Account Number: _____

Address: _____
Street (Apt No.) City St Zip

Email address: _____

Section 1:

_____ I request _____ months of forbearance (six months maximum) on my Kansas University Endowment Association loan(s) because I am unable to make scheduled payments due to financial hardship.
(Please complete section 2 and 3)

_____I request a temporary reduction of my monthly loan payment. Based on my financial situation, I will make monthly payments in the amount of $_____ (minimum monthly payment allowed $20.00 or Interest plus $10) for a period of _____ months (six months maximum). **If approved, I agree to make repayment of this amount each month as a condition of this agreement, and if 2 payments are missed, my agreement will be terminated by the Kansas University Endowment Association**.
(*Please complete section 2 and 3)*

_____I am unable to make scheduled payments due to being temporarily totally disabled.
If you are temporarily totally disabled:

1) You must be unable to work and earn money or go to school for at least 60 days in order to recover from an injury or illness.
2) You must not be requesting this deferment based on an injury or illness that existed before you applied for your loan(s), unless the condition has substantially deteriorated so that you are now temporarily totally disabled.
3) You must re-certify the disabling condition every six months to continue this deferment (up to a maximum of 12 months).

OR

_____ I am unable to work because I am caring for a spouse or dependent who is temporarily totally disabled. Name of spouse or dependent _____.
If you are caring for a spouse or dependent who is temporarily totally disabled:

1) Your spouse or dependent must have an injury or illness that requires at least 90 days of continuous nursing or similar care from you, which prevents you from working full-time.
2) You must re-certify the disabling condition every six months to continue this deferment (up to a maximum of 12 months).

(*Please complete sections 2, 3, and 4)*

Section 2 - Income and Expenses:

Monthly Income:	Monthly Expenses:
_____Gross Wages (please include spouse)	_____Housing
_____Public Assistance	_____Automobile
_____Unemployment	_____Household Expenses
_____Child Support	_____Other Loans
_____Other Income	_____Other Expenses
_____Workmen Comp	
_____TOTAL	_____TOTAL

Section 3 - Borrower Certification:

I certify that all statements made are true and correct. I also certify that I will immediately notify Kansas University Endowment Association of any change in my financial situation. I authorize a representative of the Kansas University Endowment Association to obtain from my applicable parties' pertinent information in order to verify this application. This account will remain in repayment status until this form is approved. If this form is incomplete it will be returned to me. I understand that the following terms and conditions apply to this forbearance:

1) I am not required to make payments of loan principal during the forbearance period. Interest will continue to accrue on the unpaid principal balance during this period of forbearance or reduced payment. I may pay the interest at any time.
2) If I am applying for a forbearance based on temporary total disability, I authorize any physician, hospital, or other institution having records about the disability for which I am requesting a deferment to provide information from these records to the Kansas University Endowment Association and/or ECSI (Educational Computer Systems, Inc.).
3) My forbearance will begin on the date the condition that qualifies me for the forbearance began.
4) My forbearance will end on the earlier of (a) the date the condition that qualifies me for the forbearance ends, or (b) the date the condition that qualifies me for the forbearance is expected to end, as certified by the physician who completes Section 4 of this form. My forbearance will last no longer than six months after the date my physician certifies this request.

Signature _____ Date _____

Day Phone _____ Evening Phone _____

Section 4 – Statement of Disability (Completed by Physician):

Instructions for physician: You are being asked to complete and sign this form to certify that the borrower or the borrower's spouse or dependent identified above in Section 1 is temporarily totally disabled. You may complete this form only if you are a doctor of medicine or osteopathy legally authorized to practice. Sign the certification only if the disabled person's condition meets the definition of Temporary Total Disability (as defined in Section 1). Please provide all requested information. Report dates as month-day-year.

The disabled person became unable to work and earn money or attend school, or required continuous nursing or similar care on _____. The disabling condition or care is expected to continue until _____.

Diagnosis of the disabled person's present medical condition (please describe the condition – do not use abbreviations or insurance codes):

_____

_____

_____

If different from the date you provided above, when did the disabled person's injury or illness begin? _____

_____

I certify that, in my best professional judgment, the borrower identified above in Section 2 is unable to work and earn money or attend school for at least 60 days because of a medically determinable impairment, or the borrower's spouse or dependent identified above in Section 2 requires continuous nursing or similar care for a period of at least 90 days. I am a doctor of medicine or osteopathy legally authorized to practice.

Physician's Name (printed) _____

Address _____

Physician's Signature _____

Please return form to: Kansas University Endowment Association
P.O. Box 1817
Lawrence, KS 66044-8817