STUDENT LOAN OFFICE

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: ____

____

____

Day Phone: ____

Cell Phone: ____

Email: ____

RETURN INSTRUCTIONS

Email: studentloanoffice@mercer.edu

Fax: 478-301-2673

Mail: Mercer University
ATTN: Student Loan Office
1501 Mercer University Drive
Macon, GA 31207

Account Number or Last 4-digits of SSN: ________________

Section 1: Applicable Benefits

☐ School/Internship/Residency/Fellowship Deferment
Section 2 must be completed by an official at the school/hospital of attendance/residency/fellowship/internship.
Start date: ___________________________ End date: __________________________

☐ I request a forbearance on my loans because (applicable to Nursing/Health profession and select Institutional loans)
(A) _____ I am unable to make scheduled payments due to 'Poor Health' (temporarily). Must complete sections 3, 4, **and** 5.
(B) _____ I am unable to make scheduled payment due to financial hardship. Must complete sections 3, 4, **and** supply most recent pay stub.
(C) _____ I am unable to make scheduled payment due to unemployment. Must complete section 3 **and** supply proof of registration with state unemployment agency. Start date of unemployment: ____________ Unemployment agency name: ______________________________
(D) _____ Other acceptable reason (subject to approval/supporting documentation): ____

***Interest continues to accrue during this benefit. For interest payment (1) ___ bill me monthly (2) ___ bill me at the end of my benefit**
***Certain instances may require monthly billing.**

Section 2: School/Hospital Certification

I, ____________________________, certify that the above-mentioned individual is registered at this school/hospital
School/Hospital Official's Name

____

Name of School/Hospital | Address of School/Hospital | Phone Number of School/Hospital

____ ______________________________

Signature and Title of School/Hospital Authorized Official **Date**

Section 3: 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 changes 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.

____ ______________________________

Signature of Borrower **Date**

I understand that 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.

STUDENT LOAN OFFICE

Section 4: Income Verification (attach last two pay statements)

Employer Company Name: ________________________________ Phone Number: ____________________________________

Address/City/State/Zip: ____

Pay schedule (check one): _____Weekly _____Biweekly _____ Monthly _____ Other (____________________________)

Full or part time: ____________________________ Hourly pay rate: ________________________

Loan installment expenses per month: __________________ Loan Servicer names: ____

Section 5: Statement of Temporary Disability (completed by Physician)

Patient's Name: ____ Subjective symptoms: _______________________________

Relationship to borrower: _______________________________________ Objective symptoms: ________________________________

Date when symptoms first appeared: ____________________ Diagnosis: ____

If needed please attach a separate sheet of paper

<u>Treatment</u>

First visit date: __________ Last visit date: ___________ Frequency of visit (weekly, monthly, etc.) ________________

<u>Present Condition</u>

______ Recovered ______ Unchanged ______ Improved ______ Retrogressed

______ Ambulatory ______ Bed Confined ______ House Confined ______ Hospital Confined

<u>Extent of Disability</u>

Is patient 'NOW' totally disabled? ____ yes ____ no

Will the patient be able to return to work? ____ yes ____ no

If yes, when is or was the patient able to return to work? ____________

If no, is the patient a suitable candidate for rehabilitation? ____ yes ____ no

Physician Name: ____ Physician License Number: ____________________________________

Address: ____

City State Zip code

Phone Number: ___________________________ Fax Number: _______________________

By signing below, I certify that all statements made are true and correct.

Attending Physician Signature: ____ **Date:** _________________________

Section 6: Institutional Action (for office use only)

______ Approved ______ Denied Official: ____ Date: _______________