

**AES / GRANTS SPECIAL PROGRAMS
Temporary Total Disability Deferment Request**



Please complete all sections of this form. Your request may be denied if the form is not completed correctly.

Borrower Name _____ Account Number: _____
 Address: _____ City _____ State _____ Zip Code _____
 Telephone Number(_____) _____ - _____ Alternate Telephone Number(_____) _____ - _____

Section 1 - Deferment Request - *Must be completed by the borrower or borrower's representative(a representative may complete and sign this section on the borrower's behalf if the borrower is unable to do so because of a disability)*

I meet the qualifications for a Disability Deferment and request that AES defer repayment of my loan(s).

- Defer (postpone) repayment of my account while I am TEMPORARILY TOTALLY DISABLED (Maximum eligibility is three years. Eligibility must be recertified by my physician , using this form, every six months.)
- Defer (postpone) repayment of my account while I cannot secure employment by reason of the care required for my spouse, child or parent who is disabled. (Maximum eligibility is 12 months.) Complete the following section:

_____	_____
Name of Disabled Spouse, Child or Parent	Relationship To Borrower

Section 2 - *Physician's Certification - Please print or type*

You are being asked to complete and sign this form to certify that the disabled person 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 definitions in the preceding cover letter. Please complete all requested information, you may attach additional pages if necessary. Please enter all dates as MM-DD-YY.

The disabled person became unable to work and earn money, attend school or required continuous nursing or similar care on ____/____/____ and the disabling condition or continuous care is expected to continue until ____/____/____. I certify that I am a doctor of medicine or osteopathy and legally authorized to practice and that in my best professional judgment, the disabled person named above is unable to work and earn money because of a medically determined impairment.

Physician's Signature/Date _____ Address _____

Physician's Name _____

Section 3 - Borrower Authorizations, Understandings and Certifications

I authorize any physician, hospital or other institution having records about the disability for which I am requesting a deferment of payments to make information from these records available to American Education Services (AES).

I understand that: (1) My deferment will begin no more than six months before the date AES receives this request or the date the deferment condition began, whichever is later. (2) My deferment will last no longer than six months after the date my physician certifies this request; (3) AES will not grant this deferment request unless all applicable sections of this form are completed; and (4) Principal and interest payments will be deferred. Under the conditions of deferment, I understand that I may receive monthly interest accrual/capitalization statements, however I am not required to pay the interest from the deferment period. At the end of this period, the accrued interest will be written off. (5) I am responsible for keeping the account current until the deferment is applied, and (6) Negative credit reporting will not be removed, even if the deferment is is applied retroactively.

I certify that: (1) The information provided in Section 1 above is true and correct; (2) I will provide additional documentation, as required, to AES to support my continued deferment status; (3) I will notify AES immediately when the condition that qualified me for the deferment ends; and (4) I have read, understand, and meet the conditions of the deferment for which I have applied.

Borrower/Representative Signature _____ Date _____ Name of Representative _____

Address of Representative _____ Relationship to Borrower _____

Please return form to: American Education Services • P.O. Box 2461 • Harrisburg, PA 17105-2461