



Alaska Commission on Postsecondary Education

P.O. Box 110505, Juneau Alaska 99811 • (800) 441.2962 or in Juneau 465.2962 • TTY (907) 465.3143 • AKadvantage.alaska.gov • Fax (907) 465.5316

APPLICATION FOR MEDICAL DEFERMENT OF REPAYMENT

-IMPORTANT NOTICE TO BORROWER ON REVERSE SIDE -

INSTRUCTIONS: Read the reverse side of this form and complete Section I only. Give the application to the medical authority for completion of Section II. Return the completed form to this agency at the above address within 30 days or before your loan(s) defaults, whichever is sooner. **This form must be completed legibly and in ink.** Retain a copy for your records.

WARNING: Any person who knowingly makes a false statement or misrepresentation on this form has committed the crime of perjury.

I. PERSONAL INFORMATION – To be completed by borrower PLEASE PRINT OR TYPE

Name:	Social Security Number:
Mailing Address:	Home Telephone Number:
City, State, Zip:	Business Telephone Number:

I authorize any physician, hospital, or other health service institution to provide the Alaska Commission on Postsecondary Education with the information they need to evaluate my request for deferment of loan payments. **I have also read and understand the important notice on the reverse side of this form.**

Signature of Borrower: _____ **Date:** _____

II. MEDICAL INFORMATION – To be completed by a licensed medical authority, NOT the borrower. To avoid delays, this section must be completed in its entirety. Physician's/medical office may be contacted.

- PLEASE KEEP A COPY OF THIS RELEASE FORM IN YOUR PATIENT'S RECORDS -

1. DIAGNOSIS & TREATMENT _____

2. HISTORY & EXTENT OF DISABILITY:

- a. Date illness began or injury occurred: ___/___/___
- b. Date patient ceased employment or program of study because of disability: ___/___/___
- c. First date you evaluated this patient: ___/___/___ Last date you evaluated this patient: ___/___/___
- d. Current disability rating (circle one): less than 50% 50% or more totally disabled
- e. Is the condition permanent (circle one)? YES NO
- f. Can the patient be rehabilitated (circle one)? YES NO
- g. Will the patient be capable of resuming employment or program of study with or without reasonable accommodation (circle one)? YES NO. If YES, when? ___/___/___
- h. Patient is (circle one): Ambulatory Bed Confined House Confined Hospital Confined
- i. Progress (circle one): Recovered Improved Unimproved Retrogressed

3. EXPLAIN HOW THE DISABILITY PREVENTS THE PATIENT FROM RESUMING WORK, SCHOOL OR VOCATIONAL REHABILITATION: _____

Please attach medical records & any additional information relevant to document the patient's condition.

Name of medical authority:	Telephone Number:
Address:	City, State, Zip:
Degree Information:	Licensing State: License Number:
Signature of medical authority:	Date:

MEDICAL DEFERMENT CERTIFICATION/CONDITIONS

By signing and dating this form, I certify that I am eligible for deferment of repayment and that I understand and meet the conditions indicated below. I also certify that my account is not in default status. **In addition, this form contains the appropriate medical certification attesting to the condition I am claiming.** I understand the following facts relative to any request for medical deferments:

1. Monthly payments due must be made until notification of deferment approval has been received by me.
2. My repayment schedule will be amended.
3. I have been evaluated by a licensed medical authority within the last three months.
4. It is my responsibility to obtain the necessary certification of disability before my deferment can be considered.
5. My disability must be certified by a medical authority who is licensed to practice and who is otherwise qualified to attest to the extent and the nature of my disability.
6. If I received my loan(s) before the 1996-97 school year, I must be 50% or more disabled and unable to work or attend school. If I received my loans during or after the 1996-97 school year, I must be totally disabled and unable to work or attend school to qualify.
7. My medical deferment will be granted for a maximum of six months and I must apply for a renewal if the condition continues beyond that time.
8. If my disability is based on a condition that existed at the time the loan was received, the medical authority must certify that my condition has substantially deteriorated since then and I am currently unable to work or attend school with or without reasonable accommodation.
9. If I am currently making payments on a reduced payment schedule, my reduced payment agreement is void.
10. All requirements outlined in my Promissory Note are binding.
11. Loan(s) received for, or after, the 1996-97 school year accrue interest during deferment periods. This interest may be capitalized when payments resume.
12. There is a six-month grace period following medical deferment on loans received for school year 1994-95 or earlier. Interest is charged during the grace period on loans received for school year 1987-88 and after. The total indebtedness will increase when the deferment periods end. When payments resume, accrued unpaid interest must be satisfied before payments are applied to principle.
13. If approved, my deferment status will not begin more than 30 days prior to receipt of this completed form.
14. It is my responsibility to inform the AlaskAdvantage Program of any address or name changes that occur during the life of the loan and if, or when, I no longer qualify for this medical deferment.
15. When payments resume following this deferment, the minimum monthly payment on my account will be at least fifty dollars (\$50.00) a month.
16. If this deferment request is denied, all past due amounts are payable immediately. If alternate financial arrangements are necessary, contact the Customer Service Section of the AlaskAdvantage Program, the address and phone numbers are located on the top of this form.

III. ACPE OFFICE USE ONLY			
<input type="checkbox"/> Approved	Beginning:	Ending:	
<input type="checkbox"/> Denied	Denial Reason:		
By:	Date:	Letter:	