



Medical Residency Deferment Form

CASHLoan

Instructions: Before MOHELA will grant your request, you must return the completed form to MOHELA at the address below. Please read carefully. You will receive written notice of the approval or denial of this deferment request in approximately 7 business days after MOHELA receives your residency certification.

Borrower or Cosigner Name _____ SSN

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Address _____ City _____ State _____ Zip _____

Home # () _____ - _____ Work # () _____ - _____ Alternate # () _____ - _____

Home Email _____ Work Email _____

I meet the following eligibility criteria for the Medical Residency Program and request that MOHELA defer repayment of my loans. To qualify: (1) I must be engaged in a medical residency program which must (a) be a supervised training program, and (b) require that I hold at least a Bachelor's degree before acceptance into the program. (2) In addition, my program must either (a) lead to a degree certificate from an institution of higher education, a hospital, or a health facility that offers postgraduate training, or (b) be required before I may be certified for professional practice or service. The program official must certify my enrollment in the program.

Borrower Information and Certifications
I understand that: (1) My deferment (a period during which I am entitled to postpone repayment of the principal balance of my loan) will begin on the date the deferment condition began as certified by the school or residency program official. (2) MOHELA will not grant this deferment request unless all applicable sections of this form are completed and/or any additional required documentation is provided. (3) Monthly payments will be deferred; however I am responsible for all interest that accrues during the deferment period. (4) If I do not pay the interest that accrues during this deferment, MOHELA will capitalize (add the unpaid interest to the principal balance of my loan) such interest to the extent permitted by law. This will increase the principal balance of my loan(s), may result in an increase of my monthly payment amount and may change my monthly payment due date. (5) If my account is delinquent prior to the start date of deferment, MOHELA may grant an administrative forbearance for a maximum of one month to bring my account current prior to the start date of my deferment. If I am more than one month delinquent, I authorize MOHELA to place forbearance (the temporary cessation of payments. As stated in my promissory note, forbearance will not extend the terms of repayment.) of principal and interest on my account, subject to my eligibility, prior to placing the deferment on my account. MOHELA will not clear past negative credit reporting prior to the certified beginning date of my medical residency program.

IMPORTANT PAYMENT OPTIONS

I may choose to make interest payments at any time while on deferment. I will receive quarterly interest statements that will provide me with the outstanding accrued interest and may use the accompanying coupon to make payment. I will not be charged a late fee (a fee assessed at the rate outlined in my promissory note for any payments that are more than fifteen days delinquent) during the deferment period; however any late fees assessed prior to processing the deferment will be my responsibility to pay during the deferment period or at the time I reenter repayment. I understand and agree to have any and all outstanding unpaid interest capitalized upon deferment end.

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

Borrower Signature _____ Date ____/____/____

Authorized Medical Residency Program (such as the Program Director) Official's Certification - Please print or type when completing this section.

I certify, to the best of my knowledge and belief, that the borrower named above is/was engaged in the program indicated above, and that the borrower and the borrower's program meet all the eligibility requirements specified above.

The Residency Program Official may attach a certification report listing the required information in lieu of completing this section. The borrower:

(1) Is/was enrolled/engaged in Full-Time Medical Residency

During the period from (MM/DD/YY) ____/____/____ to (MM/DD/YY) ____/____/____

(2) Is reasonably expected to complete his/her program requirements on (MM/DD/YY) ____/____/____

Name of Institution _____ School Code (if applicable) _____

Address _____ City, State, Zip _____

Name/Title of Authorized Official _____ Telephone () _____

Authorized Official's Signature _____ Date ____/____/____

Please mail form to: MOHELA CASHLoans
633 Spirit Drive
Chesterfield, MO 63005
Phone: 1-888-866-4352

Or Fax to: 1-888-387-3530