P.O. Box 3319
Wilmington DE 19804-4319
SallieMae.com

Loan Number:

Dear :

We're sorry to hear of your disability and understand that your condition may present numerous challenges. We want to assure you that we're committed to helping you in any way we can.

If your medical condition has rendered you totally and permanently disabled, please complete the enclosed form and return it to us within 90 days of your doctor's signature. Please submit your application for review using one of the following ways:

- Upload the document using the Secure Document Upload feature on Salliemae.com.
- Fax the document to 1-855-756-0011.
- Mail the document to Sallie Mae, Attn: Disability, P.O. Box 3319 Wilmington, DE 19804-4319

If you became unemployed due to a service-connected disability, you may return your Veteran's Affairs paperwork in place of the enclosed Attending Physician's Statement. Additionally, if you became totally and permanently disabled while working due to an emergency and were responsible for the protection and preservation of life, property, evidence, and/or the environment (such as emergency public safety employees, firefighters, law enforcement, and medical responders), you may provide documentation confirming that you became disabled under these circumstances in place of the enclosed Attending Physician's Statement.

Minnesota Life administers this program for us, and you may hear from them about your request.

Should you have any questions regarding this matter, call us at 855-563-5624. We're here to help you Monday - Thursday 8 a.m. to 9 p.m. and Friday 8 a.m. to 8 p.m. ET.

Sincerely,

Sallie Mae Customer Service

Enclosure: Sallie Mae Loan Total and Permanent Disability Request and Attending Physician's Statement

FC 22

Sallie Mae Private Loan
Total and Permanent Disability Request

Sallie Mae • P.O. Box 3319 • Wilmington, DE 19804-4319
Minnesota Life Insurance Company - A Securian Company • Plan Administrator
800-4-SALLIE
(800-472-5543)

STUDENT BORROWER'S STATEMENT: Complete this form if you are unable to work and earn money because of a condition that began or deteriorated after the date you obtained your loan and is expected to continue indefinitely or result in death.

PLEASE BE SURE TO SIGN AND DATE THIS REQUEST

1. Student borrower's legal name (last, first, middle initial)	2. Telephone number
3. Permanent address (street, city, state, zip)	

4. Date of birth (mo/day/yr)	5. Gender ☐ Male ☐ Female	6. Social Security number
7. What was your occupation if any, prior to your disability?		8. Date of hire (mo/day/yr)

9. Employer's name	10. Supervisor's name
11. Employer's address (street, city, state, zip)	12. Telephone number

13. Describe fully the duties you performed in that occupation

14. Circle the number of years you have completed in

Grade school 1 2 3 4 5 6 7 8 High school 9 10 11 12 GED College 1 2 3 4 Vocational training 1 2 3

15. What degrees do you hold?

16. Are you receiving Social Security, Civil Service, Armed Forces or any other disability benefit?

☐ Yes ☐ No If so, from what source

17. What special skills or training do you have?

18. Past occupation job titles (list all prior jobs) If none, please check box ☐	Starting employment dates	Ending employment dates	Job duties

19. On what date did your injury occur or disability commence?	20. On what date did you last actively perform the duties of your job, if any?
21. Are you now totally disabled and unable to work and earn money? ☐ Yes ☐ No	22. Is disability permanent? ☐ Yes ☐ No
23. If no, when will you resume all or part of your work?	24. If part, what duties?

25. Describe fully the nature of the disease or injury causing your disability

26. Are you currently enrolled in a vocational rehabilitation program? ☐ Yes ☐ No	27. If yes, list counselor's name, address and telephone number	28. If you are not currently enrolled, do you plan to attend a rehabilitation program in the future? ☐ Yes ☐ No

29. When did you first consult a physician for your disability?

30. List physicians who have treated you for your disability

Name (last, first, middle initial)	Address (street, city, state, zip)	Telephone number
Diagnosis		Date (mo/day/yr)
Name (last, first, middle initial)	Address (street, city, state, zip)	Telephone number
Diagnosis		Date (mo/day/yr)
Name (last, first, middle initial)	Address (street, city, state, zip)	Telephone number
Diagnosis		Date (mo/day/yr)

31. Dates of hospitalizations

From / To	Hospital name	
Hospital address		Telephone number
From / To	Hospital name	
Hospital address		Telephone number

32. Describe fully any work you are now doing or your current daily activities and any remarks

For the purpose of determining my request for a loan waiver, I authorize the release to Sallie Mae, Inc., and its agents and/or assigns, of all medical or nonmedical records and information, including but not limited to information regarding my health, finances and/or employment or ability to work, by anyone possessing such information, including, but not limited to, my healthcare provider, physician, medical practitioner, chiropractor, hospital, clinic or other health care facility, any insurance company, consumer credit reporting agency, the Social Security Administration, the Internal Revenue Service, the Department of Education, loan officers, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge. This shall include, but is not limited to, information regarding my health history, including, but not limited to, information about all consultations, diagnoses, prescriptions, treatments and tests, as well as any information regarding any alcohol or drug abuse, and AIDS or AIDS-related conditions. If I have applied for a discharge of a federally guaranteed loan due to a total and permanent disability, I authorize disclosure to Sallie Mae, Inc., and its agents and/or assigns, of my completed Discharge Application: Total and Permanent Disability that I have filed or may file in the future in connection with such discharge request. I understand that my health care providers may not condition treatment, payment, enrollment or eligibility for benefits on this authorization.

I authorize Sallie Mae, Inc., and its agents and/or assigns, to release any information relevant to my request for a loan waiver to persons or organizations performing services related to the request. I understand that persons or organizations that receive my information as a result of this request may have the legal right to disclose this information to other people or organizations without my knowledge, further authorization, or consent. I also authorize Sallie Mae, Inc., and its agents and/or assigns, to use the information I have provided in my federally guaranteed loan Waiver Application: Total and Permanent Disability for purposes of evaluating my request for a waiver of my private loan(s).

This authorization shall be valid for 12 months from the date it is signed or until 30 days after Sallie Mae and its agents and/or assigns have made a final determination regarding my request for a loan waiver and mailed or otherwise transmitted that determination to me, whichever is later. I have read and understand this authorization. I understand that, upon my request, I must be provided with a copy of this authorization signed by me. A photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time, except that Sallie Mae, Inc., and its agents and/or assigns, may still use and disclose the information for the purposes listed above, if they have already taken action in reliance upon this authorization. Revocation of this authorization by me in writing shall be effective as to Sallie Mae, Inc., and its agents and/or assigns, when received by each of them. If I revoke this authorization I understand that Sallie Mae will be unable to process my request for a loan waiver. Revocation of this authorization shall also serve as withdrawal of my request for a loan waiver.

By signing below, I request waiver of my private loan(s) due to my total and permanent disability. I understand that submitting this information does not guarantee that my loan(s) will be waived. If my request for a loan waiver due to total and permanent disability is denied, I will be responsible for the repayment of my loan(s), plus accrued interest.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the program, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud. The commission of fraud may subject such person to criminal and/or civil penalties.

Signature of student borrower	Date signed
X	

If this authorization is signed by someone who is not the Student Borrower listed at the top of this form, provide a description of the signer's legal authority to act for the Student Borrower.

Attending Physician's Statement

FC 21

Sallie Mae • P.O. Box 3319 • Wilmington, DE 19804-4319
Minnesota Life Insurance Company - A Securian Company • Plan Administrator
800-4-SALLIE
(800-472-5543)

SallieMae®

The student borrower is responsible for the completion of this form without expense to Sallie Mae, or the Administrator. This form must be fully completed by the attending physician.

Patient's name (last, first, middle initial)			Telephone number
Date of birth (mo/day/yr)	Height	Weight	Blood pressure reading/date

HISTORY

1. Date symptoms first appeared or accident occurred (mo/day/yr)	2. Date patient ceased work due to disability (mo/day/yr)	3. Is condition due to injury or illness arising out of patient's employment? If yes, check one	☐ Yes ☐ Injury ☐ No ☐ Illness

4. Has patient ever had same or similar condition? If yes, state when and describe.
☐ Yes ☐ No

5. Names and addresses of other treating physicians

DIAGNOSIS

1. Diagnosis including any complications for current condition	2. Patient account/file number

3. Subjective symptoms

4. Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

NATURE AND DATES OF SERVICE

1. Date of first visit (mo/day/yr)	2. Date of last visit (mo/day/yr)	3. Date of next visit (mo/day/yr)	4. Frequency

5. Has patient been hospitalized? If yes, give dates.
☐ Yes ☐ No From _____ through _____

6. Was surgery performed? If yes, state when and describe.
☐ Yes ☐ No

7. Name and address of hospital

8. Is the patient currently enrolled in any type of rehabilitation program?
☐ Yes ☐ No

9. If yes, what type of program?
☐ Cardiac ☐ Physical therapy ☐ Other _____

10. List medications

CARDIAC Functional capacity (American Heart Association)

CLASS 1	CLASS 2	CLASS 3	CLASS 4
☐ (No limitation)	☐ (Slight limitation)	☐ (Marked limitation)	☐ (Complete limitation)

1. Describe the basis for above classification

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work. *No restrictions (0 - 10%).
☐ Class 2 – Medium manual activity* (15 - 30%).
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35 - 55%).
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administration (sedentary*) activity (60 - 70%).
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75 - 100%).

1. List all restrictions and describe the basis for above classification

MENTAL/NERVOUS IMPAIRMENT

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation).
☐ Class 5 – Patient has significant loss of psychological, personal and social adjustment (severe limitations).

1. Describe the basis for above classification

PROGRESS

1. Patient has . . . (check all that apply) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed ☐ Reached maximum medical improvement - impairment rating of _____ %

2. If recovered, date released to return to work. (mo/day/yr)

3. Patient is . . . (check one)
☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

4. Patient is a suitable candidate for
☐ Trial employment ☐ Full-time ☐ Part-time ☐ Work hardening ☐ Job retraining

PROGNOSIS	REGULAR WORK	OTHER WORK
1. Is patient now totally disabled?.....	☐ Yes ☐ No If no, date released _____	☐ Yes ☐ No If no, date released _____
2. Do you expect a change in the future relating to patient's ability to work?.....	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No
a) If improvement is expected, when will patient recover sufficiently to perform duties?.....	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____

b) If no, please explain.

Remarks

Have you provided information for this patient for another insurance company or agency?
☐ Yes ☐ No If yes, list company/agency name, telephone number and claim number.

I am a doctor of ☐ medicine ☐ osteopathy/osteopathic medicine. I am legally authorized to practice in the state of _____ , and my professional license number is _____ (subject to verification through state records).

Name of attending physician (please print)	Degree	Telephone number

Physician's address (street, city, state, zip)

Signature of attending physician	Date signed	Print name of person completing this form
X		

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the plan, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud. The commission of fraud may subject such person to criminal and/or civil penalties.