Educational Assistance Program
Medical Deferment Request

Begin Date: _____

End Date: _____

(please give month/year you want deferment request to begin)

This is to request a deferment from payment of my MOAA Scholarship Fund student loan due to the following medical reason: _____. I will abide by the determination made by the Military Officers Association of America Scholarship Fund.

Student's Name: _____ **MOAA Student #: _____**

Student's Address: _____

City, State, Zip: _____

Student's Phone: _____

Student's Email: _____

As of _____(today's date), I acknowledge that I have borrowed $_____ from the MOAA Scholarship Fund and owe a balance of $_____.

I seek deferment from payment of my MOAA Educational Assistance loan(s) during the period indicated above. **I agree to notify the Military Officers Association of America (MOAA) Scholarship Fund immediately upon termination of my claimed status**. I further agree to provide documentation to support my continued deferment. I understand that by granting this deferment the MOAA Scholarship Fund has not waived any of its rights or released me from any of my obligations under my loan agreements. This deferment request is made with the knowledge and consent of my military cosigner.

Student Borrower's Signature: _____

SSN: XXX-XX-_____

Please provide the following contact information:

Military Parent Sponsor's Name: _____

Military Parent Sponsor's Phone:_____ Military Parent Sponsor's Email:_____

Military Parent Sponsor MOAA Member Number: _____

**Military Parent Sponsor must maintain paid MOAA membership if Military Parent sponsor is eligible for MOAA membership for the life of the loan.*

***Military Parent Sponsor must maintain paid Voices membership if active duty or retired enlisted (effective with 2013-2014 school year).*

CERTIFICATION OF STATUS

(Please have the doctor who is treating you complete this section.)

I certify that the claimed status is correct for the period and any additional conditions for eligibility as set forth above have been met.

Signature of Certifying Doctor: _____

Certifying Doctor's Name: _____

Certifying Doctor's Address: _____

Certifying Doctor's Phone: _____

Certifying Doctor's Email (if applicable): _____