

WARNING: Any person who knowingly makes a false statement or misrepresentation on this form is subject to criminal penalties.

INSTRUCTIONS

- Before completing this form, carefully read the entire form.
- If you need help completing this form, contact Bank of North Dakota (BND) at 833.397.0311.
- **Return completed form and required documentation within 30 days of the physician's certification (see address on back page).**

SECTION 1: BORROWER INFORMATION

Borrower Name (first, middle, last)		Social Security Number		Date of Birth (mm/dd/yyyy)	
Home Address		City		State	ZIP Code
Mailing Address (if different from home address)		City		State	ZIP Code
Telephone Number (include area code)	Cell Telephone Number (include area code)		Email Address		

SECTION 2: ELIGIBILITY REQUIREMENTS

A legal representative may complete and sign this form on your behalf if you are unable to do so because of your disability if proper documentation is received by BND.

You may defer repayment of your loan(s) if you are disabled and meet the following requirements:

1. Prevents you from engaging in any substantial gainful activity in any field of work or go to school for at least 60 months in order to recover from an injury or illness.
2. You are not requesting this deferment based on an injury or illness that existed before you applied for your loan(s), unless your condition has since substantially deteriorated and you are now disabled.

SECTION 3: BORROWER UNDERSTANDING, CERTIFICATION AND AUTHORIZATIONS

• **I understand that:**

1. I must meet the eligibility requirements listed in Section 2.
2. I am not required to make payments of loan principal during my deferment. **However, interest will accrue on my loans(s).**
3. My deferment will begin on the date the deferment is approved by BND and will be granted for a 12-month period.
4. I may apply for discharge of the debt after 36 months of approved disability deferment.
5. At any time during the deferment and prior to my loan(s) being discharged, BND may send me an Internal Revenue Service form to complete for income verification.
6. If any forms are not returned or it is determined I am no longer eligible, the deferment may expire and my loan(s) will enter repayment. BND may capitalize any outstanding interest.
7. If I am a veteran who has received a determination from the VA that I am unemployable due to a service-connected disability, I can provide documentation from the VA and will not be required to have a physician complete Section 5.
8. If my deferment does not cover all my past due payments, BND may grant a forbearance on my loan(s) for all payments due before the begin date of my deferment. Interest that accrues during this forbearance may be capitalized.

• **I certify that:**

1. The information I have provided on this form is true and correct.
2. I will provide additional documentation to my loan holder, as required, to support my deferment status.
3. I will notify my loan holder immediately if the condition that qualified me for the deferment ends.
4. I have read, understand, and meet the eligibility requirements of the deferment for which I have applied, as explained in Section 2.

• **I authorize** any physician, hospital or other institution having records about the disability for which I am requesting a deferment to make information from these records available to BND.

• **I authorize** BND to contact me regarding my request on my loan(s), including repayment of my loan(s), at the number that I provide on this form or any future number that I provide for my cellular telephone or other wireless device using automated telephone dialing equipment or artificial or prerecorded voice or text messages.

Borrower or Legal Representative (if applicable) Printed Name			
Borrower or Legal Representative Signature (If Legal Representative, provide a copy of your affidavit of guardianship with this form.)			Date (mm/dd/yyyy)
Address of Legal Representative	City	State	ZIP Code
Relationship to Borrower	Telephone Number (include area code)		

SECTION 4: DEFINITIONS

- **Capitalize** is the addition of unpaid interest to the principal balance of your loan. Interest may be capitalized when payments are postponed during deferment or forbearance periods which will increase your loan balance. As a result, more interest may accrue over the life of the loan, your monthly payment amount may increase or you may be required to make more payments to pay off your loan.
- **Discharge** is when you are released from your responsibility of the debt.
- **Substantial gainful activity** means a level of work performed for pay or profit that involves doing significant physical or mental activities or a combination of both.

SECTION 5: PHYSICIAN CERTIFICATION

Instructions for Physician:

- Complete this form only if you are a doctor of medicine or osteopathy legally authorized to practice in the United States and only if the applicant is disabled as described in Section 2. **Note: This form cannot be completed by a Nurse Practitioner.**
- **Type or print in dark ink, if completing paper copy. All fields must be completed. If a field is not applicable, enter "N/A."**
- Attach separate documentation as long as all required information from this section is included.
- If you make any changes to the information you provide in this section, you must initial each change.
- BND may contact you for additional information or documentation.

Ability to Engage in Substantial Gainful Activity

Does the applicant have a medically determinable physical or mental impairment that:

- prevents the applicant from engaging in any substantial gainful activity, in any field of work; and
- can be expected to result in death, or has lasted for a continuous period of not less than 60 months, or
- can be expected to last for a continuous period of not less than 60 months?

☐ Yes ☐ No. **If you answered no, please do not complete the rest of this application. Return the application to your patient and provide the reason(s) for disqualification.**

PHYSICIAN CERTIFICATION

Physicians Name (printed - first, middle initial, last)		State Legally Authorized to Practice Medicine	
I am a doctor of (check one below): <input type="checkbox"/> Medicine <input type="checkbox"/> Osteopathy/Osteopathic Medicine		Professional License Number (subject to state records verification)	
Address		City	State ZIP Code
Telephone Number (include area code)	Fax Number (include area code)	Email Address	
<ul style="list-style-type: none">• I certify that, in my best professional judgment, the applicant identified is unable to engage in any substantial gainful activity in any field of work by reason of a disabling physical or mental impairment that:<ul style="list-style-type: none"><input type="checkbox"/> can be expected to result in death;<input type="checkbox"/> has lasted for a continuous period of not less than 60 months; or<input type="checkbox"/> can be expected to last for a continuous period of not less than 60 months.			
Date applicant became unable to work or attend school (mm/dd/yyyy)			
Physician Signature (signature stamp is not acceptable)			Date (mm/dd/yyyy)

Keep a completed copy of this disability form and required documentation for your records. Mail completed disability request form and required documentation to:

Attn: Claims
Bank of North Dakota
PO Box 5509
Bismarck, ND 58506-5509