



# NMI SETTLEMENT FUND

POST OFFICE BOX 501247, SAIPAN, MP 96950

## AUTHORIZATION TO RELEASE INFORMATION

To Whom It May Concern:

I, \_\_\_\_\_, a resident of \_\_\_\_\_,  
whose Social Security Number is \_\_\_\_\_, and a member of the NMI Settlement Fund, do  
hereby authorize and request the release of all information checked below to any employee of the NMI  
Settlement Fund:

- |  |   |
|--|---|
| <input type="checkbox"/> Medical records             | <input type="checkbox"/> Employment records |
| <input type="checkbox"/> Wages and income tax record | <input type="checkbox"/> Payroll records    |
| <input type="checkbox"/> Other: _____                |   |

The information requested is necessary in processing and completing my membership and benefit application by the NMI Settlement Fund. For these purposes, I hereby expressly waive the privilege of confidentiality and right of privacy set forth in the applicable United States and Commonwealth laws. A copy of this authorization shall have the same force and effect as the original.

**DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.**

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

SF-2B (REV. 01/2015)