



# NMI SETTLEMENT FUND

POST OFFICE BOX 501247, SAIPAN, MP 96950

## APPLICATION FOR DISABILITY RETIREMENT ANNUITY

(PLEASE TYPE OR PRINT)

I hereby apply for Disability Retirement Annuity payable under the laws of the Northern Mariana Islands Settlement Fund.

1. NAME OF APPLICANT: (First – Middle – Last)		2. U.S. SOCIAL SECURITY No.:	
3. MAILING ADDRESS:		4. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
		5. DATE OF BIRTH:	
6. MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		7. CITIZENSHIP:	
8. CAUSE OF DISABILITY: <input type="checkbox"/> Job Related Accident <input type="checkbox"/> No Job Related		9. YEARS OF SERVICE:	
10. NAME OF SPOUSE:	11. DATE OF BIRTH:	12. U.S. SOCIAL SECURITY NO.:	

13. ARE YOU RECEIVING DISABILITY BENEFITS FOR SUBSTANTIALLY THE SAME AILMENT FROM THE UNITED STATES GOVERNMENT? If Yes, Answer A and B?  YES  NO

A. What type of benefit? \_\_\_\_\_

B. Sources of benefit: \_\_\_\_\_

IN ORDER FOR THE NORTHERN MARIANA ISLANDS SETTLEMENT FUND TO PROPERLY CONSIDER MY APPLICATION FOR DISABILITY BENEFITS, I HEREBY SUBMIT THE FOLLOWING DOCUMENTS; AS APPLICABLE:

- Accident report if disabled by job related accident.
- Service computation data from personnel office.
- Personnel action in effect at time of disability.
- Birth Certificate for myself and spouse, if married.
- Marriage certificate, if married.

Briefly Describe Your Disability

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THAT SHOULD THIS APPLICATION BE APPROVED, I PRIMOSE TO ADHERE AND ABIDE BY THE FOLLOWING CONDITIONS; AND THAT I UNDERSTAND FULLY THAT FAILURE TO COMPLY MAY RESULT IN THE REVOCATION OF THE DISABILITY BENEFITS:

1. That should my disability improves to a point that I may be gainfully employed, that I will promptly inform the Northern Mariana Islands Settlement Fund of such development.
2. That should I be employed or self-employed, I will notify the Northern Mariana Islands Settlement Fund.
3. That I must undergo a medical examination by the Board selected physicians every year for the first 5 years, and every 3 years thereafter.

*I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY MAKES FALSE STATEMENT, OR FALSIFIES OR PERMITS TO BE FALSIFIED ANY RECORDS IN ATTEMPT TO DEFRAUD THE SETTLEMENT FUND, IS GUILTY OF A MISDEMEANOR, PUNISHABLE. THEREFORE, UNDER THE LAWS OF THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, THE FUND HAS THE RIGHT TO RECOVER ANY PAYMENT MADE UNDER FALSE REPRESENTATIONS. I AFFIRM THAT THE INFORMATION I HAVE GIVEN ON THIS DOCUMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.*

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Signature of Applicant

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Date