



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		7. CITIZENSHIP:	
<input type="checkbox"/> Single <input type="checkbox"/> Widowed			
8. CAUSE OF DISABILITY:		9. YEARS OF SERVICE:	
<input type="checkbox"/> Job Related Accident <input type="checkbox"/> No Job Related			
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? <input type="checkbox"/> YES <input type="checkbox"/> 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

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.

Signature of Applicant

Date