



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:

- Medical records
- Employment records
- Wages and income tax record
- Payroll records
- 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)