# NMI SETTLEMENT FUND

POST OFFICE BOX 501247, SAIPAN, MP 96950

## APPLICATION FOR RETIREMENT ANNUITY

**I HEREBY APPLY FOR RETIREMENT ANNUITIES PAYABLE UNDER THE LAWS OF THE NORTHERN MARIANA ISLANDS RETIREMENT FUND:**

1. FULL NAME (First, Middle, Last)

2. U.S. SOCIAL SECURITY NUMBER / /

3. MAILING ADDRESS

4. E-MAIL ADDRESS

5. GENDER
☐ Male
☐ Female

4. CONTACT NUMBERS
Home: ( )
Work: ( )
Mobile: ( )

5. RESIDENCE (VILLAGE)

6. CITIZENSHIP

7. DATE OF BIRTH / /

8. MARITAL STATUS ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

9. NAME OF SPOUSE (First, Middle, Last)

10. DATE OF BIRTH / /

11. U.S. SOCIAL SECURITY NUMBER / /

**12. ELECTION TO ACCEPT FIVE (5) YEAR BONUS OF NMI CONSTITUTION, ARTICLE III, §20 (b)**

I understand that by electing to avail of the five (5) year bonus pursuant to NMI Const. Art. III, §20 (b), I may be subject to suspension or forfeiture of pension payments if re-employed by the Commonwealth Government, or any of its instrumentalities or agencies.

☐ **YES**, I elect to avail of the 5-yr bonus ☐ **NO** , I do not elect to avail of the 5-yr bonus

I hereby submit the following documents in support of this application:

- ☐ Service Computation data from Personnel Office
- ☐ Earnings records from Division of Revenues and Taxation, Form W-2 **(Three Highest Earnings)**
- ☐ Birth Certificates **(Self/Spouse/Children under 18 years of age)**
- ☐ Marriage Certificate (if married)
- ☐ Personnel action for resignation or termination
- ☐ S.S.# **(Spouse/Children under 18 years of age)**
- ☐ Most Current Payroll Check Stub/Statement

I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY MAKES FALSE STATEMENT, OR FALSIFIES OR PERMITS TO BE FALSIFIED ANY RECORDS IN AN ATTEMPT TO DEFRAUD THE RETIREMENT 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

## SINGLE SUM DEATH BENEFIT AND/OR REFUND OF CONTRIBUTIONS

**I HEREBY DESIGNATE** the following beneficiary(ies) to receive the Single Sum Death Benefit and/or any refund from the Fund upon my death. This designation will remain in effect unless changed by me ***in writing.***

| Name of Beneficiary | S.S. Number | Relationship | % Share |
|---|---|---|---|
| | / / | | |
| | / / | | |
| | / / | | |

## DEPENDENT CHILDREN AT TIME OF RETIREMENT

| Age(s) ***Seventeen (17) and Under*** | | Age(s) ***18 to 22*** – Full Time Student | |
|---|---|---|---|
| Name | DOB | Name | DOB |
| | / / | | / / |
| | / / | | / / |
| | / / | | / / |
| | / / | | / / |
| | / / | | / / |
| | / / | | / / |

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## AUTHORIZATION TO RELEASE INFORMATION

To Whom It May Concern:

I, _____, a resident of _____, whose Social Security Number is _____, a member of the NMI Retirement Fund, do hereby authorize and request the release of all information checked below to any employee of the NMI Retirement Fund for official use:

- ☐ Medical records
- ☐ Wages and income tax record
- ☐ Payroll records
- ☐ Employment records
- ☐ Other information: _____ (Please Specify)

The information requested is necessary in processing and completing my membership and benefit application by the NMI Retirement 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

## APPLICATION FOR IDENTIFICATION CARD

***(Please type or print)***

RF-2A (Rev. 4/2010)

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## APPLICATION FOR IDENTIFICATION CARD

*(Please type or print)*

*To the Applicant:*
You must present valid identification with your completed form. You must also sign the back of the card and provide a 1" x 1" photo of yourself before laminating your card.

The Identification card is a valid ID, and may serve for any other purpose.

Thank you

Mark One Box: ☐ Retiree ☐ Surviving Spouse ☐ Disability Annuitant

| | | | |
|---|---|---|---|
| NAME: Last, First Middle | | SOCIAL SECURITY NUMBER: | |
| DATE OF BIRTH: (Month/Day/Year) | | WEIGHT | HEIGHT |
| MAILING ADDRESS: (PO Box or Street Name) | | | |
| | | | |
| | | | |
| GENDER: ☐ Male ☐ Female | | LAST DUTY STATION OR RESIDENCE IN THE CNMI: ☐ Saipan ☐ Rota ☐ Tinian | |
| RETIREMENT DATE/ DATE BENEFIT BEGAN: | | SIGNATURE/DATE: (X) | |

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## Application AND Authorization to Commence OR Cease Allotment from Pay of Employees/Retirees

| | |
|---|---|
| NAME OF ALLOTER *(Last, First, Middle Initial)* Social Security Number: | NAME OF ALLOTER *(Last, First, Middle Initial)* |
| ADDRESS OF ALLOTTER *(PO Box or Number, Street, City State Zip Code)* | ADDRESS OF ALLOTTER *(PO Box or Number, Street, City State Zip Code)* |
| TYPE OF PAYMENT *(Check all that apply)*<br>☐ Retiree ☐ Surviving Child<br>☐ Surviving Spouse<br>☐ Employee/Other | TYPE OF PAYMENT *(Check all that apply)*<br>☐ Retiree ☐ Surviving Child<br>☐ Surviving Spouse<br>☐ Employee/Other |
| IF EMPLOYED, SECTION: | IF EMPLOYED, SECTION: |
| AMOUNT OF BI-WEEKLY ALLOTMENT *(Amount in Words/Figures)*<br>*/$* | AMOUNT OF BI-WEEKLY ALLOTMENT *(Amount in Words/Figures)*<br>*/$* |
| BEGIN ALLOTMENT *(Starting Pay Period)* | CEASE ALLOTMENT *(Starting Pay Period)* |
| NAME AND ADDRESS OF BANK/INSTITUTION | NAME AND ADDRESS OF BANK/INSTITUTION |
| CREDIT ALLOTMENT TO ACCOUNT NUMBER: | CEASE ALLOTMENT TO ACCOUNT NUMBER: |
| TYPE OF ACCOUNT *(Check one box)*<br>☐ SAVINGS *(Attach copy of savings statement or passbook)*<br>☐ CHECKING *(Attach pre-printed deposit ticket from your Checkbook)* | PLEASE TELL US WHY YOU ARE DISCONTINUING THIS ALLOTMENT<br>*(Optional – this information can help improve our services)* |
| BANK ROUTING NUMBER: | |
| REQUEST AND APPROVAL TO COMMENCE ALLOTMENT<br>*I HEREBY request and authorize allotment to be paid at the end of each Pay Period from my pay, as requested above and subject to approval, and to continue from the period stated until revoked by me in writing.* | REQUEST & APPROVAL TO CEASE ALLOTMENT<br>*I HEREBY request and authorize discontinuance of previously authorized and approved allotment from my pay as indicated above.* |
| FULL SIGNATURE OF ALLOTTER / DATE | FULL SIGNATURE OF ALLOTTER / DATE |
| APPROVED / DATE | APPROVED / DATE |

IF YOU REQUIRE ASSISTANCE, PLEASE CONTACT:

| SAIPAN | ROTA | TINIAN |
|---|---|---|
| PO Box 501247 | PO Box 968 | PO Box 520276 |
| Saipan, MP 96950 | Rota, MP 96951 | Tinian, MP 969512 |
| Ph: 670/322-3863 | Ph: 670/532-9516 | Ph: 670/433-3733 |
| Fax: 670/664-8080 | Fax: 670/532-9486 | Fax: 670/433-3863 |

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# Election to Continue or Reject Insurance

(For use by retiring Employees only)

*INSTRUCTION:*
**This form must be completed:**
**1) by an active member who is currently enrolled in the government group life insurance program; and**
**2) at the time of retirement to let us know if you wish to continue or reject the government life insurance coverage you are with while actively employed.**

**PLEASE TYPE OR PRINT LEGIBLY. THANK YOU.**

**In conjunction with my application for a retirement annuity**, I do hereby elect, on the date indicated below, to:

_____ **Continue** my life insurance coverage with the Government Group Life Insurance to the extent such coverage is available to retirees. I also understand that the Retirement Fund will pay the employer's share of the premium cost for coverage and I attach my CNMI Government Group Life Insurance Enrollment form to continue coverage.

_____ **Reject** continuation of my life insurance coverage with the Government Group Life Insurance. I understand that by **rejecting** life insurance, I will never be able to enroll in the government life insurance program in the future as a retiree.

_____ _____

Member Signature Date

**FOR RETIREMENT FUND OFFICIAL USE ONLY:**

Date of Retirement: _____ Coverage at Retirement: $ _____

Reviewed by: _____ Approved by: _____

Date: _____ Date: _____

RF-2E (Rev 03/2012)

| Form **W-4P** | **Withholding Certificate for Pension or Annuity Payments** | OMB No. 1545-0074 |
|---|---|---|
| Department of the Treasury<br>Internal Revenue Service | | 20**11** |

**Purpose.** Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W-4P to choose (a) not to have any federal income tax withheld from the payment (except for eligible rollover distributions, or payments to U.S. citizens delivered outside the United States or its possessions) or (b) to have an additional amount of tax withheld.

Your options depend on whether the payment is periodic, non-periodic, or an eligible rollover distribution, as explained on Pages 3 and 4. Your previously filed Form W-4P will remain in effect if you do not file a Form W-4P for 2011.

**What do I need to do?** Complete lines **A** through **G** of the **Personal Allowances Worksheet.** Use the additional worksheets on Page 2 to further adjust your withholding allowances for itemized deductions, adjustments to income, any additional standard deduction, certain credits, or multiple pensions/more-than-one income situations. If you do not want any federal income tax withheld (see *Purpose* above), you can skip the worksheets and go directly to the Form W-4P below.

**Sign this form.** Form W-4P is not valid unless you sign it.

## **Personal Allowances Worksheet** (Keep for your records)

A Enter "1" for **yourself** if no one else can claim you as a dependent ..... A _____

B Enter "1" if:
- You are single and have only one pension; or
- You are married, have only one pension, and your spouse has no income subject to withholding; or
- Your income from a second pension or a job, or your spouse's pension or wages (or the total of all) is $1500 or less

..... B _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a spouse who has income subject to withholding or you have more than one source of income subject to withholding. (Entering "-0-" may help you avoid having to little tax withheld.) ..... C _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return ..... D _____

E Enter "1" if you will file as **head of household** on your tax return ..... E _____

F **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If you total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. ..... F _____

G Add lines A through F and enter total here. **(Note.** *This may be different from the number of exemptions you claim on your tax return.)* ..... G _____

For accuracy, **complete all worksheets that apply.**
- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you have more than one source of income subject to withholding or a spouse with income subject to withholding **and** your combined income from all sources exceeds $18,000 (32,000 if married), see **Multiple Pensions/More-Than-One-Income Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line G on line 2 of Form W-4P below.

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## IMPORTANT NOTICE TO NEW RETIREES

(EXCLUDING SURVIVING SPOUSES & CHILDREN)

*Please read this form carefully. It is **applicable to you only if you are enrolled** in the Government Health*

Effective June 14, 2007, Public Law 15-70 amended provisions of the Government Health Insurance Program as follows:

> "Annuitants shall be provided with an option, to be exercised within six (6) months of the date of retirement, to continue their Commonwealth government health insurance coverage under the same group terms and conditions as that government coverage, if any, is offered each fiscal year to Commonwealth government employees. The fund assumes no liability to the annuitant for group health insurance coverage beyond the payment of the Government's share of the premiums for that fiscal year on behalf of an electing annuitant as provided in this section. Any person who declines to exercise the health insurance option within six (6) months of the date of retirement, or who exercises the option and subsequently cancels health insurance coverage more than six (6) months after the date of retirement, shall not be entitled to reapply for coverage."

By signing below, I hereby acknowledge that I have read and understand the provision cited above. I further acknowledge that this provision to exercise my one-time option to enroll or to waive enrollment in the Government Group Health Insurance program shall expire as of _____, 20____. I affirm that by failing to take any action by the date stated, I have waived the option to enroll. In the event I enroll before the date stated, I will remit any amounts owed for premiums due as of the effective date of the approval of my application for Government Group Health Insurance Enrollment.

**RETIREE:** **DATE:**

_____ _____

**FUND REPRESENTATIVE:** **DATE:**

_____ _____