STATEMENT OF UNDERSTANDING AND
DISPOSITION OF NAF HEALTH, DENTAL and LIFE INSURANCE
DURING LEAVE WITHOUT PAY

I _____ understand the following concerning the disposition of my health, dental, or life insurance during my approved LWOP:

1. I must request LWOP in advance.
2. I am requesting weeks/months of LWOP.
3. I am liable to my employer for payment or repayment of my health and/or life insurance premiums during my period of LWOP.
4. I may request to suspend my health, dental and/or life insurance premiums during my period of LWOP and understand that if this option is elected, I can not participate or re-enroll in the health, dental and/or life insurance plans until the next open enrollment period.

Health, Dental and Life Insurance Participation Status

☐ I currently do not have health, dental or life insurance.

☐ I am currently contributing to:

☐ Health, Dental and Life Insurance
☐ Health and Dental Insurance
☐ Health and Life Insurance
☐ Health Insurance
☐ Life Insurance
☐ Stand Alone Dental Plan

☐ I am being called/recalled to active duty and would like to terminate my health insurance. I understand that I may enroll in health insurance within 31 days following the termination of my military Tri-Care coverage or upon my return to my NAF position, whichever is later.

☐ I am being called/recalled to active duty and would like to continue health insurance. I understand that premiums will be paid by the NAFI until I return to my NAF position. I understand I may be required to pay the employee portion of the premium unless I am a reservist in support of a contingency operation.

Payment Options

☐ I elect to discontinue payment of my insurance premiums, and based on that decision, I will not sign an agreement to repay any premiums related debt stemming from my employer's payment of premiums while I am on LWOP. I realize nonpayment of premiums will result in the cancellation of my insurance and that I will not be permitted to enroll in the health, dental and/or life insurance plan again until the next open season.

☐ I will reimburse my employer upon my return from LWOP. I understand that if I do not reimburse my employer, the debt will be collected from my pay as prescribed by Nonappropriated Fund (NAF) Financial Services for debt collection.

☐ I will pay my premiums in advance (via Mail OR in-person) as a monthly/bi-weekly payments. Checks will be made payable to the employing organization named below for the applicable amount due to:

Employing Organization's Name:

Mailing Address for Payment:

By signing below, I am confirming my understanding and agreement of my obligation, as applicable to my participation/election above.

Signature of employee Date

Signature of Supervisor or Approving Official Date

1. Original to Supervisor/Manager or Financial Management Office **2. Copy to employee** *3. Copy to NAF HRO*