**STATEMENT OF UNDERSTANDING – LEAVE WITHOUT PAY**

**NAF HEALTH/DENTAL/LIFE INSURANCE BENEFITS**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that I am liable to my employer for payment of NAF Health and Life insurance premiums during my Leave Without Pay (LWOP) period.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have elected to prepay my NAF Health and Life Insurance premiums. Arrangements for payment of my contributions were coordinated through the NAF Financial Management Office. The servicing payroll office has provided FMD with the amount of my NAF Health and Life insurance premiums.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that my Retirement, 401(k), and the flexible spending account are suspended during the period of LWOP.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am aware that if I fail to return to duty within 3 calendar days of the expiration of the approved period of LWOP, I will be separated for abandonment of position.

My monthly premiums are: $ \_\_\_\_\_\_\_\_

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I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request to cancel my NAF Health and Life insurance as I do not have the funds to continue to pay my premiums. I am aware that upon approval of my LWOP, my NAF Health and Life Insurance Benefits will be cancelled by my employer and that I will not be permitted to enroll in the health benefit plan again until the next open season.

I understand and agree to the above information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Printed Name Employee Signature and date

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FM Chief Printed Name FM Chief Signature and date