

NAVPERSCOM NON-APPROPRIATED FUND GROUP BENEFITS ENROLLMENT FORM

SUPPORTING DIRECTIVE BUPERSINST 5300.10A

PRIVACY ACT STATEMENT: SECTION 5 OF THE UNITED STATES CODE 552A(B), AUTHORIZES COLLECTION OF THIS INFORMATION. THE INFORMATION YOU SUPPLY WILL BE USED TO MANAGE AND ADMINISTER BENEFIT PROGRAMS FOR NON-APPROPRIATED FUND (NAF) DEPARTMENT OF THE NAVY PERSONNEL. COLLECTION OF THIS INFORMATION IS AUTHORIZED BY EXECUTIVE ORDER 9397 AND 5 U.S.C. SECTION 301. FURNISHING THE INFORMATION THIS FORM, INCLUDING YOUR SOCIAL SECURITY NUMBER AND OTHER PERSONAL INFORMATION, IS VOLUNTARY. HOWEVER, FAILURE TO PROVIDE THE INFORMATION MAY DELAY OR PREVENT ADMINISTRATION OF BENEFIT FUNCTIONS.

NAME:	SSN:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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STREET ADDRESS:	CITY, STATE, ZIP:
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ACTIVITY NAME AND LOCATION:

DATE OF BIRTH: (MM/DD/YYYY)	DATE EMPLOYED: (MM/DD/YYYY)
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MARITAL STATUS:
 SINGLE OR LEGALLY SEPARATED MARRIED DIVORCED

INSTRUCTIONS: THE FOLLOWING SHALL BE COMPLETED AND ATTACHED TO THIS FORM FOR ALL INITIAL ENROLLMENTS OR CHANGES EVEN IF ONLY ONE PLAN IS INVOLVED.

1. ALL PARTS OF THIS FORM SHALL BE COMPLETED FOR INITIAL ENROLLMENT
2. A SPECIFIC MEDICAL PLAN ENROLLMENT FORM IF THE CHANGE INVOLVES A MEDICAL PLAN CHANGE.
3. A COMPLETE BENEFICIARY DESIGNATION FORM

A. TYPE OF ENROLLMENT
 This is a new enrollment. NEW HIRE _____ STATUS CHANGE TO REGULAR _____ REEMPLOYED _____
 This is a change in coverage election during open season. _____
 This is a change in coverage due to a change in family status. _____
 This is a termination or waiver of enrollment. _____

B. MEDICAL PLAN ELECTION
 I ELECT DOD Uniform Health Plan _____ HMO (WHERE AVAILABLE) _____
 I ELECT to cover Self Only _____ Myself and 1 Dependent _____ Family _____
 I DECLINE ALL Medical Coverage _____
 I ELECT to terminate all current medical plan coverage _____

C. DENTAL PLAN ELECTION
 I am enrolled in a medical plan and also want to enroll in the Dental Plan _____
 I DECLINE ALL Dental Plan coverage _____
 I ELECT to terminate my current dental plan coverage _____

D. LIFE INSURANCE ELECTION
 I Elect Basic Coverage: _____ Option A (1 times pay) _____ Option B (2 times pay) _____
 I DECLINE Basic: _____ Option A _____ Option B _____ All Life Insurance Coverage _____
 I ELECT to terminate: Basic _____ Option A _____ Option B _____
 _____ All life insurance coverage

E. DISABILITY PLAN ELECTION
 I ELECT to enroll in the Disability Plan _____
 I DECLINE Disability Plan coverage _____

F. RETIREMENT PLAN
 I ELECT to enroll in the retirement plan with deductions starting the pay period after _____
 I have one year of regular service. _____.
 I WAIVE retirement plan coverage and understand that I can join at any time without prior credited service. _____
 I ELECT to discontinue participation in the retirement plan. I understand that I will Not receive credited service or any periods of discontinuance.

EMPLOYEE'S SIGNATURE:	DATE:
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