

PARTICIPATION INFORMATION

(AIR FORCE NONAPPROPRIATED FUND RETIREMENT PLAN)

*AUTHORITY: 10 USC 9013, Secretary of the Air Force; powers and duties; delegation by; implemented by AFMAN 34-302.
 PRINCIPAL PURPOSE(S): Used to document employee participation in the AFNAF Retirement Plan.
 ROUTINE USES: May be disclosed to Federal, state, and local government agencies in the pursuit of their official duties. May also be used for other lawful purposes, including law enforcement and/or litigation. The SSN is used for identification of the individual and records.
 DISCLOSURE IS VOLUNTARY: Failure to provide the information, including the SSN could delay or preclude payment of benefits according to the plan.
 SORN: Department of the Air Force F034 AF SVA B*

NOTE: Part V Signature and Certification, on reverse of this form must be completed before submission of the form to AFWB (NAF Insurance).

NAME (Last, First, Middle Initial)		SSN	
COMPLETE ADDRESS (Include Street, City, State, and ZIP Code)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	
	EMPLOYING NAFI	INSTALLATION	
BENEFICIARY NAME (Last, First, Middle Initial)	RELATIONSHIP	AGE	SOCIAL SECURITY NUMBER

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries as survive me, unless otherwise provided herein. If no designated beneficiary survives me, settlement will be made as provided in plan document.

I. ENROLLMENT

I have been counseled regarding my eligibility to enroll in the retirement plan and I elect: TO ENROLL NOT TO ENROLL
(If enrollment is desired, complete and send to AFWB (NAF Insurance). If enrollment is not desired, date and file in Employee's OPF.)

DATE OF REGULAR FULL-TIME APPOINTMENT	DATE CONTRIBUTIONS ARE TO BEGIN	PRIOR AIR FORCE NAFI OR OTHER DOD NAFI SERVICE AND RETIREMENT PARTICIPATION (If yes, complete section below.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMPLOYING NAFI	INSTALLATION	PERIOD	
		FROM	TO

(Indicate answer by placing "X" in proper column.)

	YES	NO
Prior participation in AFNAF Retirement Plan	<input type="checkbox"/>	<input type="checkbox"/>
Retirement contributions were refunded at termination.	<input type="checkbox"/>	<input type="checkbox"/>
Desire to reinstate prior period of participation by redeposit of withdrawn contributions	<input type="checkbox"/>	<input type="checkbox"/>
Prior participation in other DOD NAFI Retirement Plan (Specify branch of service) _____	<input type="checkbox"/>	<input type="checkbox"/>
Terminated within 90 days of current AFNAF employment	<input type="checkbox"/>	<input type="checkbox"/>
Terminated last employment due to a transfer of function	<input type="checkbox"/>	<input type="checkbox"/>

II. ELECTION TO REINSTATE PRIOR PARTICIPATION BY REDEPOSIT

I desire to reinstate my prior participation of _____ through _____
 (Date) (Date)
 in the AFNAF Retirement Program by repayment of the sum of my contributions previously withdrawn *(and interest if applicable)*
 in the amount of \$ _____. I understand such repayment must be made within 180 days of my most recent date of
 AF NAFI employment or this option will no longer be available.

III. NOTICE OF CHANGE OF NAME

I request that the name appearing on my previous records as _____
 be changed to _____ effective _____
 because _____

IV. CHANGE OF BENEFICIARY

I wish to revoke the name of any previous beneficiary(ies) and designate the following beneficiary(ies) effective _____

BENEFICIARY NAME <i>(Last, First, Middle Initial)</i>	RELATIONSHIP	AGE	SOCIAL SECURITY NUMBER

This change/nomination of beneficiary shall take effect upon receipt of this instrument at HQ USAF and when so received the change shall be operative as of the date specified above whether or not I am alive at the time of such receipt but without prejudice to the AF central retirement fund on account of any payment made by it before such receipt.

REMARKS

V. SIGNATURE AND CERTIFICATION (MUST BE COMPLETED)

EMPLOYEE:

I certify that the actions indicated on this form are correct in regard to my participation in the AFNAF Retirement Program.

EMPLOYEE'S SIGNATURE	DATE
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PERSONNEL OFFICER OR AUTHORIZED REPRESENTATIVE:

I certify that the answers and statements on this form are complete and true to the best of my knowledge.

TYPED NAME AND TITLE OF PERSONNEL REPRESENTATIVE	SIGNATURE	DATE
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