2025 BEP Enrollment Form

Complete, sign and mail both pages of this enrollment form to:

ATTN: Office of Human Resources
American University
4400 Massachusetts Avenue, NW
Washington, DC 20016-8054

Or email your completed and signed form to hrpayrollhelp@american.edu.

If you have a qualifying event or HIPAA special enrollment and wish to change your benefits, you must submit supporting dated documentation with your BEP enrollment form within 30 days of the qualifying event. The benefit change must be consistent with the event that occurred.

If you need assistance, email hrpayrollhelp@american.edu or call (202) 885-3836.

Retiree Information

First Name	Middle Initial	Last Name		Suffix
Street Address		**City**	**State**	**Zip Code**

Marital Status
○ Single ○ Married ○ Widowed ○ Domestic Partnership

Sex
○ Male ○ Female

Email	Phone	Retirement Date	BEP Coverage Date

Medical Plan

1. Action
○ Not Eligible ○ Continue Coverage ○ Change Coverage ○ Drop Coverage ○ Add Dependent(s) ○ Drop Dependent(s)

2. Medical Plan
○ CareFirst PPO ○ CareFirst High Deductible Health Plan (HDHP) ○ Kaiser Permanente HMO

3. Level of Coverage
○ Individual ○ Individual + Child(ren) ○ Individual + Spouse/Domestic Partner ○ Family

4. Indicate all persons covered under the medical plan (attach another sheet, if necessary).

	First Name	Last Name	SSN	Date of Birth	Sex	
					M	F
Retiree					○	○
Spouse					○	○
Domestic Partner					○	○
Child					○	○
Child					○	○

5. Are you covered by Medicare Part B?
○ Yes ○ No

6. Is your spouse covered by Medicare Part B?
○ Yes ○ No

Complete Page 2 of the Benefits Extension Plan Form.

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Dental Plan

1. Action
○ Not Eligible ○ Continue Coverage ○ Change Coverage ○ Drop Coverage ○ Add Dependent(s) ○ Drop Dependent(s)

2. Dental Plan
○ Delta Dental Basic ○ Delta Dental Comprehensive

3. Level of Coverage
○ Individual ○ Individual + Child(ren) ○ Individual + Spouse/Domestic Partner ○ Family

4. Indicate all persons covered under the dental plan (attach another sheet, if necessary).

	First Name	Last Name	SSN	Date of Birth	Sex	
					M	F
Retiree					○	○
Spouse					○	○
Domestic Partner					○	○
Child					○	○
Child					○	○

Vision Plan

1. Action
○ Not Eligible ○ Continue Coverage ○ Change Coverage ○ Drop Coverage ○ Add Dependent(s) ○ Drop Dependent(s)

2. Vision Plan
○ CareFirst Vision Basic ○ CareFirst Vision Enhanced

3. Level of Coverage
○ Individual ○ Individual + Child(ren) ○ Individual + Spouse/Domestic Partner ○ Family

4. Indicate all persons covered under the vision plan (attach another sheet, if necessary).

	First Name	Last Name	SSN	Date of Birth	Sex	
					M	F
Retiree					○	○
Spouse					○	○
Domestic Partner					○	○
Child					○	○
Child					○	○

Authorization and Signature

I hereby submit the above information to American University's Office of Human Resources Benefits Team for my benefit coverage(s). I understand that, under the provisions of the BEP, if I am currently not enrolled in health coverage, then I am unable to enroll in medical, dental, or vision coverage at this time.

Signature _____ Date _____