AMERICAN UNIVERSITY
WASHINGTON, DC
OFFICE of HUMAN RESOURCES

Email completed enrollment form to:
American University Human Resources Benefits Team
hrpayrollhelp@american.edu
Call (202) 885-3836 for assistance.

2024 BEP Enrollment Form

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 Number**

Retirement Date | **BEP Coverage Effective Date**

Medical Plan

☐ Not Eligible ☐ Continue Coverage ☐ Change Coverage ☐ Drop Coverage ☐ Add Dependent(s) ☐ Drop Dependent(s)

1. Plan Provider ☐ CareFirst BlueChoice Advantage ☐ Kaiser Permanente

2. Level of Coverage ☐ Individual ☐ Individual + 1 ☐ Family

3. 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						

4. Are you covered by Medicare Part B? ☐ Yes ☐ No

5. Is your spouse covered by Medicare Part B? ☐ Yes ☐ No

Dental Plan

☐ Not Eligible ☐ Continue Coverage ☐ Change Coverage ☐ Drop Coverage ☐ Add Dependent(s) ☐ Drop Dependent(s)

1. Dental Plan ☐ Delta Dental Comprehensive ☐ Delta Dental Basic

2. Level of Coverage ☐ Individual ☐ Individual + 1 ☐ Family

3. 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						

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 health or dental coverage at this time.

Signature _____ Date _____