2027 BEP Enrollment Form

Complete, sign and email your completed and signed form to hrpayrollhelp@american.edu.

Or mail both pages of this enrollment form to:

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

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				
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 Premier ○ CareFirst 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
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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7. Spouse and Domestic Partner Surcharge/Waiver Attestation (for medical plan only)

If your spouse/domestic partner is eligible for medical plan coverage through their own employer sponsored medical plan or is retired and has access to a health plan through their previous employer or retirement plan, and you choose to enroll them in an AU medical plan, a surcharge of $125 per month will apply. The domestic partner or spousal surcharge will be waived if:

- You and your spouse or domestic partner both work at American University
- You do not enroll your spouse/domestic partner in the American University medical plan
- Your spouse/domestic partner is not employed, or if employed, is not eligible for benefits through their employment.
- Your spouse/domestic partner is eligible for and/or enrolled in Medicare/Medicaid and not offered a supplement through a retiree health plan

I certify that the information I have provided in support of my spouse/domestic partner enrollment in the AU 2027 medical plan is true, complete, and accurate to the best of my knowledge. I understand that eligibility for medical benefits is governed by the terms of the applicable benefit plans and American University policies. I further understand and acknowledge that any false, misleading, incomplete, or fraudulent statement or representation regarding my eligibility or the eligibility of my spouse/domestic partner for coverage may result in corrective action by the University.
By completing the attestation, I acknowledge that if it is determined that I have knowingly provided false or misleading information regarding eligibility for benefits coverage, the University may take appropriate disciplinary action, up to and including termination of employment, in addition to any other remedies available under applicable law, plan documents, or University policies.

Spouse or Domestic Partner Surcharge/Waiver Attestation (select appropriate option).

- ○ I elect to enroll my spouse in an AU medical plan. I attest that my spouse IS eligible to participate in their employer sponsored medical plan or has access to a health plan through their previous employer or retirement plan.
- ○ I elect to enroll my spouse in an AU medical plan. I attest that my spouse is NOT eligible to participate in their employer sponsored medical plan or does not have access to a health plan through their previous employer or retirement plan.
- ○ I elect to enroll my spouse in an AU medical plan. I attest that my spouse is an AU employee.
- ○ I elect to enroll my domestic partner in an AU medical plan. I attest that my domestic partner IS eligible to participate in their employer sponsored medical plan or has access to a health plan through their previous employer or retirement plan.
- ○ I elect to enroll my domestic partner in an AU medical plan. I attest that my domestic partner is NOT eligible to participate in their employer sponsored medical plan or does not have access to a health plan through their previous employer or retirement plan.
- ○ I elect to enroll my domestic partner in an AU medical plan. I attest that my domestic partner is an AU employee.

Complete Page 3 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
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
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 _____