Epic Hearing Plan Enrollment Form
Georgia State University

Name (First, Middle, Last)	Employee Number #	☐Male ☐Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	
Phone #	Email Address (Optional)	

First select your level of coverage

- ☐ Employee Only $1.80
- ☐ Employee+ Spouse $3.08
- ☐ Employee+ Children $2.40
- ☐ Family $3.68

List dependents

Spouse	Date of Birth	Gender
____________	____________	____________
Children	**Date of Birth**	**Gender**
____________	____________	____________
Children	**Date of Birth**	**Gender**
____________	____________	____________
Children	**Date of Birth**	**Gender**
____________	____________	____________
Children	**Date of Birth**	**Gender**
____________	____________	____________

I authorize Georgia State University to deduct the premiums from my paycheck for the Epic Hearing benefit

Name	Signature	Date