

**ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE**  
 RELIANCE STANDARD LIFE INSURANCE COMPANY  
**ENROLLMENT CARD**

**PLEASE FOLLOW THESE IMPORTANT INSTRUCTIONS:**

1. Type or print using ball point pen.
2. Return all copies to the Benefits Department, CB 1045.

**POLICYHOLDER:** The University of North Carolina at Chapel Hill **POLICY NO.** VAR 50, 510A

**Applicant's Name: (Print)** \_\_\_\_\_  
(First) (Middle Initial) (Last) **Soc. Sec. No.** \_\_\_\_\_

**Home Address: (Print)** \_\_\_\_\_  
(Street) (City) (State) (Zip) **Date of Birth** \_\_\_\_\_

**Beneficiary: Principal (Print)** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
**Contingent (Print)** \_\_\_\_\_ **Relationship** \_\_\_\_\_

<input type="checkbox"/> Employee:	Benefit Amount _____	Monthly Premium _____	<input type="checkbox"/> I desire to participate in the insurance program as presented to me and hereby authorize my employer to make the necessary deduction from my wage or salary to pay my premium. This authorization may be withdrawn by written request to the University at any time.
<input type="checkbox"/> Spouse (name: _____ )	_____	_____	

I do not wish to participate in this insurance program at this time.

Spouse (name: \_\_\_\_\_ ) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ **Signature of Applicant** \_\_\_\_\_

Child (name: \_\_\_\_\_ ) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ **Campus address (Box No.):** \_\_\_\_\_

Child (name: \_\_\_\_\_ ) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Child (name: \_\_\_\_\_ ) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  EPA Employee  Staff Employee

**Total Monthly Premium** \_\_\_\_\_ *Printed in USA*