

**The University of North Carolina at Chapel Hill
Dental Application**



**ASSURANT Employee
Benefits**

Name of employee (*Last, first, middle initial*) _____ Social Security no. _____

Employee's address (*Street number and name, city, state, zip code*) _____

Occupation _____	Birthdate (Mo., Day, Yr.) _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Department _____
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Dental Insurance Options

Please check coverage desired: Employee Only (\$31.50/Mo.) Employee & Child(ren) (\$60.38/Mo.)
 Employee & Spouse (\$58.88/Mo.) Employee, Spouse & Child(ren) (\$87.76/Mo.)

Dependent Information

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I hereby authorize The University of North Carolina at Chapel Hill to deduct from my earnings the amount required to cover the premiums for the coverage selected. I reserve the right to revoke this deduction authorization at any time on written notice to my employer.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee signature _____ Date _____

FOR EMPLOYER USE ONLY	Hire date _____	Group #G58472	Late applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employee deduction \$ _____	Effective date of coverage _____	

Return both copies to UNC at Chapel Hill Benefits Department.

Union Security Insurance Company

Assurant Employee Benefits 2323 Grand Boulevard Kansas City Missouri 64108-2670

Form 10 (7/99) (UNC)

KC3841NC (8/2007)

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