Effective Date: _____

DOUBLE SPOUSE PARTICIPATION
ISU Plan Benefits Eligible Employees

MEDICAL	
PPO - ALLIANCE SELECT	
HMO - BLUE ADVANTAGE	

DENTAL	
DELTA DENTAL -- BASIC	
DELTA DENTAL -- COMPREHENSIVE	

A. CONTRACT HOLDER INFORMATION

LAST NAME	FIRST NAME	INITIAL
UNIVERSITY ID	DEPARTMENT	BASE OF EMPLOYMENT

B. SPOUSE'S INFORMATION

LAST NAME	FIRST NAME	INITIAL
UNIVERSITY ID	DEPARTMENT	BASE OF EMPLOYMENT

The above named individuals hereby request to participate in a shared contract as self and family plan. To be eligible, both individuals must be ISU Plan benefits eligible employees.

In the event that either employee terminates or becomes ineligible to participate in this program, or for some reason does not have any pay coming for any month in which a premium is due, the remaining employee, by his/her signature below, authorizes the appropriate deduction to be taken from his/her paycheck.

It is understood that the contract shall be issued in the name listed under "Contract Holder".

DATE SIGNED	SIGNATURE OF CONTRACT HOLDER
DATE SIGNED	SIGNATURE OF SPOUSE