SISC III MEMBERSHIP CHANGE FORM

SISC III SELF-INSURED SCHOOLS OF CALIFORNIA — Schools Helping Schools

PRINT CLEARLY IN BLACK OR BLUE INK

SUBSCRIBER INFORMATION

NAME OF SUBSCRIBER LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

DISTRICT USE ONLY (Required)

DISTRICT NAME (Do not abbreviate):

REQUESTED EFFECTIVE DATE:

MEDICAL GROUP NO.:

DISTRICT APPROVED:
INITIALS: ________________

NAME CHANGE

☐ SUBSCRIBER ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ CHILD

	LAST NAME (PRINT)	FIRST NAME (PRINT)
OLD NAME(S):		
NEW NAME(S):		

SUBSCRIBER OLD ADDRESS	SUBSCRIBER NEW ADDRESS
OLD ADDRESS	NEW ADDRESS
OLD CITY/STATE/ZIP	NEW CITY/STATE/ZIP
OLD PHONE NO.	NEW PHONE NO.

SOCIAL SECURITY NO. AND DATE OF BIRTH CHANGES

☐ CHANGE SOCIAL SECURITY NO. FOR: ______________________ SSN FROM: ______________ SSN TO: ______________

☐ CHANGE DATE OF BIRTH FOR: ______________________ DOB FROM: ______________ DOB TO: ______________

DEPENDENT CHANGES PROOF OF ELIGILBILITY REQUIRED (i.e.: BIRTH/MARRIAGE/DOMESTIC PARTNER CERTIFICATE)

☐ ADD ☐ DELETE	☐ SPOUSE ☐ DOMESTIC PARTNER ☐ M ☐ F	LAST NAME (PRINT)			FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	
		REASON FOR CHANGE:						
☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY–REQUIRED)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)			FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	
		REASON FOR CHANGE:						
☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY–REQUIRED)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)			FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	
		REASON FOR CHANGE:						
☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY–REQUIRED)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)			FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.	
		REASON FOR CHANGE:						
☐ MEDICAL ☐ DENTAL ☐ VISION	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY–REQUIRED)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

SUBSCRIBER SIGNATURE	DATE

MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT