SISC
Self-Insured Schools of California
*Schools Helping Schools*

# SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK OR BLUE INK

| DISTRICT USE ONLY |
|---|
| DISTRICT NAME: |
| EFFECTIVE DATE: |
| MEDICAL GROUP #: |
| DISTRICT INITIALS: |

## SUBSCRIBER INFORMATION

| LAST NAME (PRINT) | FIRST NAME (PRINT) | SSN |
|---|---|---|
| | | |

**EFFECTIVE/TERMINATION DATE UPDATE OR REINSTATEMENT REQUEST (SUBSCRIBER ONLY – APPLIES TO ALL ENROLLED OR PREVIOUSLY ENROLLED DEPENDENTS)**

EFFECTIVE DATE FROM: _____ EFFECTIVE DATE TO: _____

TERMINATION DATE FROM: _____ TERMINATION DATE TO: _____

REINSTATEMENT DATE (WITH NO BREAK IN COVERAGE): _____

## SSN & DOB CHANGES (SUBSCRIBER OR DEPENDENTS)

CHANGE SSN FOR: _____ SSN FROM: _____ SSN TO: _____

CHANGE DOB FOR: _____ DOB FROM: _____ DOB TO: _____

## DEPENDENT CHANGES – PROOF OF ELIGIBILITY REQUIRED (i.e. BIRTH/MARRIAGE/DOMESTIC PARTNER CERTIFICATE)

| | | | | | |
|---|---|---|---|---|---|
| ☐ ADD<br>☐ DELETE | ☐ SPOUSE<br>☐ DOMESTIC PARTNER | LAST NAME (PRINT) | FIRST NAME (PRINT) | MI | SSN |
| ☐ MEDICAL<br>☐ DENTAL<br>☐ VISION | ☐ M ☐ F | REASON FOR CHANGE: | | | |
| | DATE OF BIRTH | ENROLLED IN OTHER HEALTH PLAN?<br>☐ YES ☐ NO | IPA CODE (HMO ONLY) | PCP CODE (HMO ONLY) | IS THIS YOUR CURRENT PROVIDER?<br>☐ YES ☐ NO |

| | | | | | |
|---|---|---|---|---|---|
| ☐ ADD<br>☐ DELETE | ☐ DEPENDENT CHILD | LAST NAME (PRINT) | FIRST NAME (PRINT) | MI | SSN |
| ☐ MEDICAL<br>☐ DENTAL<br>☐ VISION | ☐ M ☐ F | REASON FOR CHANGE | | | |
| | DATE OF BIRTH: | ENROLLED IN OTHER HEALTH PLAN?<br>☐ YES ☐ NO | IPA CODE (HMO ONLY) | PCP CODE (HMO ONLY) | IS THIS YOUR CURRENT PROVIDER?<br>☐ YES ☐ NO |

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|---|---|---|---|---|---|
| ☐ ADD<br>☐ DELETE | ☐ DEPENDENT CHILD | LAST NAME (PRINT) | FIRST NAME (PRINT) | MI | SSN |
| ☐ MEDICAL<br>☐ DENTAL<br>☐ VISION | ☐ M ☐ F | REASON FOR CHANGE | | | |
| | DATE OF BIRTH: | ENROLLED IN OTHER HEALTH PLAN?<br>☐ YES ☐ NO | IPA CODE (HMO ONLY) | PCP CODE (HMO ONLY) | IS THIS YOUR CURRENT PROVIDER?<br>☐ YES ☐ NO |

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|---|---|---|---|---|---|
| ☐ ADD<br>☐ DELETE | ☐ DEPENDENT CHILD | LAST NAME (PRINT) | FIRST NAME (PRINT) | MI | SSN |
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| | DATE OF BIRTH | ENROLLED IN OTHER HEALTH PLAN?<br>☐ YES ☐ NO | IPA CODE (HMO ONLY) | PCP CODE (HMO ONLY) | IS THIS YOUR CURRENT PROVIDER?<br>☐ YES ☐ NO |

| SUBSCRIBER SIGNATURE: | DATE: |
|---|---|
| | |