SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK INK

SUBSCRIBER CHANGES

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 name only ☐ Spouse ☐ Domestic Partner ☐ Child

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

NEW NAME(S):

SUBSCRIBER OLD ADDRESS	SUBSCRIBER NEW ADDRESS
Old Address	New Address
City/State/Zip	City/State/Zip
Old Phone No. ( )	New Phone No. ( )

SOCIAL SECURITY NO. AND DATE OF BIRTH CHANGES

☐ CHANGE SOCIAL SECURITY NO. FOR: _____ FROM: _____ TO: _____

☐ CHANGE DATE OF BIRTH FOR: _____ FROM: _____ TO: _____

DEPENDENT CHANGES *Proof of eligibility required (i.e. birth/marriage/domestic partner certificate).*

District Use		LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
☐ ADD ☐ DELETE	☐ SPOUSE ☐ DOMESTIC PARTNER ☐ M ☐ F				
		REASON FOR CHANGE:			☐ SPOUSE IS EMPLOYED AT SAME DISTRICT

	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ MEDICAL ☐ DENTAL ☐ VISION	_____/_____/_____		☐ YES ☐ NO	☐ YES ☐ NO			☐YES ☐NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ MEDICAL ☐ DENTAL ☐ VISION	_____/_____/_____		☐ YES ☐ NO	☐ YES ☐ NO			☐YES ☐NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ MEDICAL ☐ DENTAL ☐ VISION	_____/_____/_____		☐ YES ☐ NO	☐ YES ☐ NO			☐YES ☐NO

☐ ADD ☐ DELETE	☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
		REASON FOR CHANGE:			

	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	IPA (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER?
☐ MEDICAL ☐ DENTAL ☐ VISION	_____/_____/_____		☐ YES ☐ NO	☐ YES ☐ NO			☐YES ☐NO

SUBSCRIBER SIGNATURE	DATE

MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT