SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK OR BLUE 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: __________

75% OPTION – PROVIDE SPOUSE SOCIAL SECURITY NO.

NAME CHANGE

☐ Subscriber name only ☐ 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
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 ☐ 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 (HMO ONLY – REQUIRED)	PCP (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 (HMO ONLY – REQUIRED)	PCP (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 (HMO ONLY – REQUIRED)	PCP (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 (HMO ONLY – REQUIRED)	PCP (HMO ONLY – REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐YES ☐NO

SUBSCRIBER SIGNATURE	DATE

MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT