SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

SISC III MEMBERSHIP CHANGE FORM

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

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

NEW NAME(S):

SUBSCRIBER OLD ADDRESS

OLD ADDRESS

OLD CITY/STATE/ZIP

OLD PHONE NO.

SUBSCRIBER NEW ADDRESS

NEW ADDRESS

NEW CITY/STATE/ZIP

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)

DISTRICT USE	☐ SPOUSE	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
☐ ADD	☐ DOMESTIC PARTNER				
☐ DELETE	☐ M ☐ F	REASON FOR CHANGE:			

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

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

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

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

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

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

	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN?	ENROLLED IN OTHER HEALTH PLAN?	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (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

Rev. 03/2017