SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

DISENROLLMENT REQUEST – SISC GROUP PLAN

Use to disenroll from the following plans:
BLUE SHIELD 65+ HMO/ Medicare Advantage Plan
COMPANIONCARE / Medicare Supplement Plan or
KAISER SENIOR ADVANTAGE / Medicare Advantage Plan

Member Name: _____

Address: _____

City: _____State:_____Zip:_____County:_____

Telephone: ( ) ____-_____ Date of Birth: ___/____/_____ SS#:_____

Please read carefully and initial next to your request before signing and dating the form.

DISENROLLMENT FROM COMPANIONCARE:

When the medical portion of this plan is terminated then the Medicare Part D prescription drug plan is also terminated automatically with the same termination date.

_____ I wish to disenroll from CompanionCare/Medicare Supplement (Leave SISC Coverage)
Initial

_____ I wish to disenroll from CompanionCare and enroll in a SISC Medicare Advantage Plan
Initial (must be offered by district)

DISENROLLMENT FROM MEDICARE ADVANTAGE PLAN:

Blue Shield Medicare Advantage or Kaiser Senior Advantage

Members who have requested to disenroll must continue to receive all medical care from their HMO plan until the effective date of the disenrollment except for emergencies, out of area urgent care or authorized referrals.

_____ I wish to disenroll from SISC coverage (Returns member to Medicare coverage)
Initial

_____ I wish to disenroll from Kaiser Senior Advantage & enroll with Kaiser direct (Leave SISC Coverage)
Initial

_____ I wish to disenroll from my Medicare Advantage Plan & enroll in CompanionCare
Initial (must be offered by district)

REQUESTED DISENROLLMENT DATE: _____
Medicare benefits may only be restored on the first of a month. Disenrollment request requires a 45 calendar day advance notice. NO Exceptions

I understand that by leaving SISC coverage I may not re-enroll at a later date.

Member Signature: _____Date:_____

Return to SISC via secure portal HealthX or fax
HealthX: https://secure.healthx.com/sisc.aspx
Fax: (661) 636-4094

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