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

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

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

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

SUBSCRIBER SIGNATURE:	DATE: