SISC
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	SUBSCRIBER NEW ADDRESS
OLD ADDRESS	NEW ADDRESS
OLD CITY/STATE/ZIP	NEW CITY/STATE/ZIP
OLD PHONE NO.	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							
☐ 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 CODE (HMO ONLY- REQUIRED)	PCP CODE (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 CODE (HMO ONLY- REQUIRED)	PCP CODE (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 CODE (HMO ONLY- REQUIRED)	PCP CODE (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 CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY–REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

SUBSCRIBER SIGNATURE	DATE

MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT. SUBMIT VIA SISCconnect.org, SISC'S SECURE WEB PORTAL.