

SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK OR BLUE INK

SUBSCRIBER CHANGES					DISTRICT USE ONLY (Required)		
NAME OF SUBSCRIBER LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.			
				DISTRICT NAME (Do not abbreviate): VISALIA UNIFIED			
				REQUESTED EFFECTIVE DATE: ____/____/____			
NAME CHANGE				MEDICAL GROUP NO.: ____/____/____			
☐ Subscriber name only ☐ Spouse ☐ Domestic Partner ☐ Child				DISTRICT APPROVED			
OLD NAME(S):		LAST NAME (PRINT)		FIRST NAME (PRINT)		INITIALS: _____	
NEW NAME(S):						75% OPTION – PROVIDE SPOUSE SOCIAL SECURITY NO.	

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 <i>Proof of eligibility required (i.e. birth/marriage/domestic partner certificate).</i>							
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

SUBSCRIBER SIGNATURE								DATE	