



# 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.
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**DISTRICT USE ONLY (Required)**

DISTRICT NAME (Do not abbreviate):
REQUESTED EFFECTIVE DATE:
MEDICAL GROUP NO.:
DISTRICT APPROVED: INITIALS: _____

**NAME CHANGE**

<input type="checkbox"/> SUBSCRIBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> 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**

<input type="checkbox"/> CHANGE SOCIAL SECURITY NO. FOR: _____	SSN FROM: _____	SSN TO: _____
<input type="checkbox"/> CHANGE DATE OF BIRTH FOR: _____	DOB FROM: _____	DOB TO: _____

**DEPENDENT CHANGES PROOF OF ELIGIBILITY REQUIRED (i.e.: BIRTH/MARRIAGE/DOMESTIC PARTNER CERTIFICATE)**

<b>DISTRICT USE</b>	<input type="checkbox"/> SPOUSE	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.		
<input type="checkbox"/> ADD	<input type="checkbox"/> DOMESTIC PARTNER	REASON FOR CHANGE:					
<input type="checkbox"/> DELETE	<input type="checkbox"/> M <input type="checkbox"/> F						
<input type="checkbox"/> MEDICAL	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DENTAL							
<input type="checkbox"/> VISION							

<input type="checkbox"/> ADD	<input type="checkbox"/> SON	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.		
<input type="checkbox"/> DELETE	<input type="checkbox"/> DAUGHTER	REASON FOR CHANGE:					
<input type="checkbox"/> MEDICAL	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DENTAL							
<input type="checkbox"/> VISION							

<input type="checkbox"/> ADD	<input type="checkbox"/> SON	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.		
<input type="checkbox"/> DELETE	<input type="checkbox"/> DAUGHTER	REASON FOR CHANGE:					
<input type="checkbox"/> MEDICAL	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DENTAL							
<input type="checkbox"/> VISION							

<input type="checkbox"/> ADD	<input type="checkbox"/> SON	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.		
<input type="checkbox"/> DELETE	<input type="checkbox"/> DAUGHTER	REASON FOR CHANGE:					
<input type="checkbox"/> MEDICAL	DATE OF BIRTH	AGE	ELIGIBLE FOR OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ENROLLED IN OTHER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IPA CODE (HMO ONLY- REQUIRED)	PCP CODE (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DENTAL							
<input type="checkbox"/> VISION							

SUBSCRIBER SIGNATURE	DATE
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**MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT**

## Dependent Eligibility Documentation Chart

The following verification documents are required to enroll a dependent in health benefit plans  
 SISC requires the Social Security Numbers for all dependents to be covered on the plans  
 SISC reserves the right to request additional documentation to substantiate eligibility

DEPENDENT TYPE	REQUIRED DOCUMENTATION
<b>Spouse</b>	<ul style="list-style-type: none"> <li>• Prior year’s Federal Tax Form that shows the couple was married (financial information may be blocked out)</li> <li>• Marriage Certificate for newly married couple where tax return is not available</li> </ul>
<b>Domestic Partner</b>	<ul style="list-style-type: none"> <li>• Certificate of Registered Domestic Partnership issued by State of California</li> <li>• SISC Affidavit of Domestic Partnership (when applicable)</li> </ul>
<b>Children, Stepchildren, and/or Adopted Children up to age 26</b>	<ul style="list-style-type: none"> <li>• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name &amp; child’s DOB)</li> <li>• Legal Adoption Documentation</li> </ul>
<b>Legal Guardianship up to age 18</b>	<ul style="list-style-type: none"> <li>• Legal Court Documentation establishing Guardianship</li> </ul>
<b>Disabled Dependents over age 26</b>	<p><b><i>Anthem Blue Cross (All items listed below are required)</i></b></p> <ul style="list-style-type: none"> <li>• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name &amp; child’s DOB)</li> <li>• Prior year’s Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out)</li> <li>• Proof of 6 months prior creditable coverage</li> <li>• Completed Anthem Disabled Dependent Certification Form</li> </ul> <p><b><i>Blue Shield (All items listed below are required)</i></b></p> <ul style="list-style-type: none"> <li>• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name &amp; child’s DOB)</li> <li>• Prior year’s Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out)</li> <li>• Proof of 6 months prior creditable coverage</li> <li>• Completed Declaration of Disability for Overage Dependent Child</li> </ul> <p><b><i>Kaiser (All items listed below are required)</i></b></p> <ul style="list-style-type: none"> <li>• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name &amp; child’s DOB)</li> <li>• Prior year’s Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out)</li> <li>• Proof of 6 months prior creditable coverage</li> <li>• Completed Disabled Dependent Enrollment Application</li> <li>• Most recent Kaiser Certification notice (if available)</li> </ul>