SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK OR BLUE INK

SUBSCRIBER CHANGES

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: __________
75% OPTION – PROVIDE SPOUSE SOCIAL SECURITY NO.

NAME CHANGE

☐ Subscriber name only ☐ Spouse ☐ Domestic Partner ☐ Child

	LAST NAME (PRINT)	FIRST NAME (PRINT)
OLD NAME(S):		
NEW NAME(S):		

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 *Proof of eligibility 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 (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

☐ 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

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
Spouse	• Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out) • Marriage Certificate for newly married couple where tax return is not available
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal Court Documentation establishing Guardianship
Disabled Dependents over age 26	***Anthem Blue Cross (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form ***Blue Shield (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Declaration of Disability for Overage Dependent Child ***Kaiser (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)