

SISC MEMBERSHIP CHANGE FORM

Please print clearly using a black or blue ink ballpoint pen.

District Name _____

REQUESTED EFFECTIVE DATE: / /

NAME OF SUBSCRIBER (LAST) _____	(FIRST) _____
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SOCIAL SECURITY NUMBER

MEDICAL GROUP NUMBER

NAME CHANGE	ADDRESS CHANGE
<input type="checkbox"/> Subscriber name only <input type="checkbox"/> Dependent(s)	New Address
NEW NAME	City/State/Zip
	New Phone No. ()

SUBSCRIBER CHANGES

CHANGE MY SOCIAL SECURITY NUMBER FROM: _____ - _____ TO: _____ - _____
(Please submit copy of Social Security card.)

CHANGE MY DATE OF BIRTH FROM: ____/____/____ TO ____/____/____

DEPENDENT CHANGES

ADD SPOUSE: Date of Marriage: ____/____/____ ADD DOMESTIC PARTNER Date of Partnership: ____/____/____ (Documentation must be on file with employer.)
 SPOUSE IS EMPLOYED AT SAME DISTRICT.

ADD FAMILY MEMBER: Effective Date: ____/____/____ Reason: _____
 (Documentation is required for guardianship, adoptions and dependent re-enrollments.)

REMOVE FAMILY MEMBER(S): Effective Date: ____/____/____ Name(s): _____ Reason: _____
 (Documentation required. 30 days notice required for retro termination request.)

CHANGE DATE OF BIRTH FOR: _____ FROM: ____/____/____ TO ____/____/____

FAMILY ADDITIONS

RELATION	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	Date of Birth	Age	Other Health Coverage	If children are age 19 or over, you must check the appropriate boxes below.		Medical Group/IPA Office No.	IPA Primary Care Physician Code	Is this your current doctor?
								Qualified as IRS dependent	Full time student			
SPOUSE/DP <input type="checkbox"/> male <input type="checkbox"/> female							<input type="checkbox"/> yes <input type="checkbox"/> no					<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son <input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son <input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son <input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son <input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son <input type="checkbox"/> daughter							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no

SUBSCRIBER'S SIGNATURE _____

DATE _____