SISC
Self-Insured Schools of California
Schools Helping Schools

Butte Schools
Self-Funded Programs

SISC III MEMBERSHIP CHANGE FORM

PRINT CLEARLY IN BLACK OR BLUE INK

DISTRICT USE ONLY
DISTRICT NAME:
EFFECTIVE DATE:
MEDICAL GROUP #:
DISTRICT INITIALS:

SUBSCRIBER INFORMATION

LAST NAME (PRINT)	FIRST NAME (PRINT)	SSN

EFFECTIVE/TERMINATION DATE UPDATE OR REINSTATEMENT REQUEST (SUBSCRIBER ONLY – APPLIES TO ALL ENROLLED OR PREVIOUSLY ENROLLED DEPENDENTS)

EFFECTIVE DATE FROM: ______________________ EFFECTIVE DATE TO: ______________________

TERMINATION DATE FROM: ______________________ TERMINATION DATE TO: ______________________

REINSTATEMENT DATE (WITH NO BREAK IN COVERAGE): ______________________

SSN & DOB CHANGES (SUBSCRIBER OR DEPENDENTS)

CHANGE SSN FOR: ______________________ SSN FROM: ______________ SSN TO: ______________

CHANGE DOB FOR: ______________________ DOB FROM: ______________ DOB TO: ______________

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

☐ ADD ☐ DELETE	☐ SPOUSE ☐ DOMESTIC PARTNER	LAST NAME (PRINT)	FIRST NAME (PRINT)		MI	SSN
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ M ☐ F	REASON FOR CHANGE:				
	DATE OF BIRTH	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY)	PCP CODE (HMO ONLY)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ ADD ☐ DELETE	☐ DEPENDENT CHILD	LAST NAME (PRINT)	FIRST NAME (PRINT)		MI	SSN
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ M ☐ F	REASON FOR CHANGE				
	DATE OF BIRTH:	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY)	PCP CODE (HMO ONLY)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ ADD ☐ DELETE	☐ DEPENDENT CHILD	LAST NAME (PRINT)	FIRST NAME (PRINT)		MI	SSN
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ M ☐ F	REASON FOR CHANGE				
	DATE OF BIRTH:	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY)	PCP CODE (HMO ONLY)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ ADD ☐ DELETE	☐ DEPENDENT CHILD	LAST NAME (PRINT)	FIRST NAME (PRINT)		MI	SSN
☐ MEDICAL ☐ DENTAL ☐ VISION	☐ M ☐ F	REASON FOR CHANGE:				
	DATE OF BIRTH	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	IPA CODE (HMO ONLY)	PCP CODE (HMO ONLY)		IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

SUBSCRIBER SIGNATURE:	DATE:

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)