Print Form

SISC MEMBERSHIP CHANGE FORM

Please print clearly using a black ink ballpoint pen.

DISTRICT USE ONLY
DISTRICT NAME: Santa Barbara County Education Office

NAME OF SUBSCRIBER (LAST) (FIRST)

SOCIAL SECURITY NUMBER

NAME CHANGE

❑ Subscriber name only ❑ Dependent(s)

NEW NAME

REQUESTED EFFECTIVE DATE: / /

MEDICAL GROUP NUMBER

OLD ADDRESS	NEW ADDRESS
Old Address	New Address
City/State/Zip	City/State/Zip
Old Phone No. ( )	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:_____/_____/_____ (Please submit documentation.)
❑ SPOUSE IS EMPLOYED AT SAME DISTRICT. Plan Type _____(i.e., PPO, HMO)

❑ 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 is required. 30 days notice required for retro termination request.)

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

FAMILY ADDITIONS									HMO		
RELATION	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	Date of Birth	Age	Is eligible for other health plan?	Is enrolled in other health plan?	Medical Group/ IPA Office No.	IPA Primary Care Physician Code	Is this your current doctor?
SPOUSE/DP ❑ male ❑ female							❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no

SUBSCRIBER'S SIGNATURE

DATE