Print Form

SISC MEMBERSHIP CHANGE FORM

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

District Name Santa Barbara County Education Office

REQUESTED EFFECTIVE DATE: / /

NAME OF SUBSCRIBER (LAST) (FIRST)	SOCIAL SECURITY NUMBER	MEDICAL GROUP NUMBER

NAME CHANGE

❑ Subscriber name only ❑ Dependent(s)

NEW NAME

ADDRESS CHANGE

New Address

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 / HMO

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. Qualified as IRS dependent	Full time student	Medical Group/IPA Office No.	IPA Primary Care Physician Code	Is this your current doctor?
SPOUSE/DP ❑ male ❑ female							❑ yes ❑ no					❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no
❑ son ❑ daughter							❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no			❑ yes ❑ no

SUBSCRIBER'S SIGNATURE	DATE