

# SISC MEMBERSHIP CHANGE FORM

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

District Name **San Benito High School**

REQUESTED EFFECTIVE DATE:     /     /

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

### NAME CHANGE

Subscriber name only     Dependent(s)

NEW NAME

New Address

City/State/Zip

New Phone No. (     )     -     -     

### ADDRESS CHANGE

CHANGE MY SOCIAL SECURITY NUMBER FROM:     -     -     /     /     /     -     -     -     TO:     -     -     /     /     /     -     -     -

(Please submit copy of Social Security card.)

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

### SUBSCRIBER 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.

### DEPENDENT CHANGES

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?
SPOUSE/DP							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Full time student <input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> male <input type="checkbox"/> female							<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"/> 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"/> 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"/> 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"/> 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

### HMO

SUBSCRIBER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_