

Remember HMO Plans need provider information

SISC III MEMBERSHIP CHANGE FORM

	Y IN BLACK OR	BLUE INK								
SUBSCRIBER CHANGES NAME OF SUBSCRIBER LAST NAME (PRINT)			NT) FIRST NAME (PRINT)			SOCIAL SECURITY NO.		DISTRICT USE ONLY (Required)		
					SOCIAL SECURITY NO.	DISTRICT NAME (Do not abbreviate): Coachella Valley Unifed School				
IPA(HMO Only):PCP(HMO Only):			Only):	Current Provider Yes No		District REQUESTED EFFECTIVE DATE:				
NAME CHAI							Y = _ = _	MEDICAL GROUP	NO ·	
☐ Subscriber name only ☐ Spouse ☐ Domestic Partner ☐ Child OLD NAME(S): LAST NAME (PRINT)						FIRST NAME (PRINT)				
,						DISTRICT APPROVED				
NEW NAME(S):								75% OPTION - PR		
								SOCIAL SECURIT		
SUBSCRIBER OLD ADDRESS						SUBSCRIBER NEW ADDRESS				
Old Address						New Address				
City/State/Zip						City/State/Zip				
OU S	GL N-									
Old Phone No.						New Phone No.				
SOCIAL SEC	URITY NO. AN	D DATE O	F BIRT	H CHANGES			No. of the			
□ CHANGE SOCIAL SECURITY NO. FOR: FROM: TO: TO:										
CHANGE DATE OF BIRTH FOR: FROM: TO:										
DEPENDENT	CHANGES P	root of elia	ibility	required (i.e. hi	rth/marriage/do	mestic partner certificate).				
District Use	□ SPOUSE	LAST NAMI	E (PRINT)	itil/iliairiage/doi	FIRST NAME (PRINT)	- 11	AI SOCIALS	ECURITY NO.	
□ ADD	☐ DOMESTIC									
□ DELETE	PARTNER									
	OM D F	REASON FOR	R CHANG	BE:						
□ MEDICAL	DATE OF BIRTH	1	AGE	ELIGIBLE FOR OTHER HEALTH	ENROLLED IN OTHER HEALTH	IPA (HMO ONLY - REQUIRED)	PCP (HMO	ONLY - REQUIRED)	IS THIS YOUR CURRENT	
☐ DENTAL				PLAN?	PLAN?				PROVIDER?	
☐ VISION									□YES □NO	
□ ADD	☐ SON LAST NAME (PRINT)					FIRST NAME (PRINT) M		SOCIAL SECURITY NO.		
□ DELETE	□ DAUGHTER									
						<u> </u>				
	REASON FOR CHANGE:									
☐ MEDICAL	DATE OF BIRTH		AGE	ELIGIBLE FOR OTHER HEALTH	ENROLLED IN OTHER HEALTH	IPA (HMO ONLY - REQUIRED)	PCP (HMO	ONLY - REQUIRED)	IS THIS YOUR CURRENT	
C) DENTAL				PLAN?	PLAN?				PROVIDER?	
☐ VISION							.]		□YES □NO	
□ ADĐ	□ SON	LAST NAME	(PRINT)			FIRST NAME (PRINT)	N	II SOCIAL S	ECURITY NO.	
DELETE	☐ DAUGHTER									
		REASON FO	OR CHAN	IGE:						
☐ MEDICAL	DATE OF BIRTH	 ,	AGE	ELIGIBLE FOR	ENROLLED IN	IPA (HMO ONLY - REQUIRED)	L PCP (HMO)	ONLY - REQUIRED)	I IS THIS YOUR	
CI DENTAL				OTHER HEALTH PLAN?	OTHER HEALTH PLAN?	II A (I MO ONE) - NEGOTIED	I OF (THEO	ONET - NEGOINED)	CURRENT PROVIDER?	
□ VISION				☐ YE\$ ☐ NO	☐ YES ☐ NO				□YES □NO	
□ ADD	□ SON	LAST NAME	(PRINT)			FIRST NAME (PRINT)	I M	II SOCIAL SI	ECURITY NO.	
D DELETE	1 30N						2001			
		REASON FO	FOR CHANGE:					1		
☐ MEDICAL	DATE OF BIRTH		AGE	ELIGIBLE FOR OTHER HEALTH	ENROLLED IN OTHER HEALTH	IPA (HMO ONLY - REQUIRED)	PCP (HMÖ	ONLY - REQUIRED)	IS THIS YOUR	
☐ DENTAL				PLAN?	PLAN?				CURRENT PROVIDER?	
□ VISION	-			T 129 U NO	☐ YES ☐ NO				□YES □NO	
SUBSCRIBE	RSIGNATURE				<u> </u>		I	DATE		