

SISC MEMBERSHIP CHANGE FORM

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

District Name _____

REQUESTED EFFECTIVE DATE: ____ / ____ / ____

NAME OF SUBSCRIBER (LAST) _____ (FIRST) _____

SOCIAL SECURITY NUMBER _____

MEDICAL GROUP NUMBER _____

NAME CHANGE

Subscriber name only Dependent(s)

ADDRESS CHANGE

New Address _____

City/State/Zip _____

New Phone No. (_____) _____

NEW NAME _____

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: _____ 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 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/PA Office No.	HMO IPA Primary Care Physician Code	Is this your current doctor?
<input type="checkbox"/> SPOUSE/DP <input type="checkbox"/> male <input type="checkbox"/> female							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Qualified as IRS dependent <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"/> son							<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"/> yes <input type="checkbox"/> no
<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"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<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"/> yes <input type="checkbox"/> no
<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"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<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"/> yes <input type="checkbox"/> no
<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"/> yes <input type="checkbox"/> no
<input type="checkbox"/> son							<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"/> yes <input type="checkbox"/> no
<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"/> yes <input type="checkbox"/> no

SUBSCRIBER'S SIGNATURE _____

DATE _____

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name	Hire date (mm/dd/yyyy)
Group number	Enrollment unit
Effective enrollment/change date (mm/dd/yyyy)	

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance) New group: Yes No

New Hire (complete sections A, B, C, D)
 Open Enrollment (complete sections A, B, C, D)
 Health Plan (Check one) HMO Plan Deductible Plan Other _____
 Loss of Other Coverage (complete sections A, B, C, D) Other (please specify) _____
 Name change (complete sections A, B, C, D) From: _____ To: _____
 Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known)	Social Security No.
Name (Last, First, MI)	Birth Date (mm/dd/yyyy) Gender <input type="checkbox"/> M <input type="checkbox"/> F
Home Address	City State ZIP
Work Phone	Home Phone E-mail *
Ethnicity	Preferred Language

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Spouse/domestic partner name:		Birth Date (mm/dd/yyyy)
Former last name (if any):		Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
Relationship:		Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
Relationship:		Medical Record No.
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Dependent name:		Birth Date (mm/dd/yyyy)
Relationship:		Medical Record No.

Do any of dependents above live at another address? Yes No If yes, complete the following:

Name (Last, First, MI): _____ Address: _____

D. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee/Applicant signature	Date	Employer signature	Date
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*Additional documentation may be required.



Basic Life/Voluntary Life Change Form

Underwritten by: United of Omaha Life Insurance Company



Brought to you by:



Mutual of Omaha

Instructions - Complete and sign below. Return completed form to your Employer.

Type of Change

- BASIC LIFE Beneficiary Change - VOLUNTARY LIFE Beneficiary Change
 Both BASIC/SUPPLEMENTAL Beneficiary Change
 NAME CHANGE - Previous Name

Employer Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (*).)

*Employer's Name: _____

District Name: _____ District #: _____ Group ID: G000ABIH

Employee Section (Please print clearly. Required fields are marked with an asterisk (*).)

*Last Name _____ *First Name: _____ MI: _____

*Social Security Number: _____ *Birth Date (MM/DD/YYYY): _____ *Gender: Male Female
 Marital Status: Single Married Divorced Widowed

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage.

SIGNATURE OF EMPLOYEE _____ DATE ____/____/____