

## 2023-2024 Existing Member Change Form For CURRENTLY enrolled Kaiser and Blue Shield Members

District Name:	Effective date of change:			
Employee Name (Please print):	Social Security Number:			
Signature:	Date:			
PLAN CHANGES INDICATE YOUR <u>CURRENT</u> PLAN HERE PLEASE NOTE: All plan options listed below may not be available based on your bargaining unit plan selections				
<i>KAISER:</i> □ \$0 OV HMO	☐ \$10 OV HMO	☐ \$20 OV HMO ☐ \$30 OV HMO		
□ \$500DHMO	\$1000DHMO	□нс	☐ HDHP/H.S.AA/B	
BLUE SHIELD: 100% PPO	☐ 90% PPO	☐ 80% PPO		☐ HDHP/H.S.AA/B
Anchor Bronze	☐ WABE			
INDICATE YOUR <u>NEW</u> PLAN SELECTION HERE (Additional forms and backup documents may be required) PLEASE NOTE: All plan options listed below may not be available based on your bargaining unit plan selections				
\$0 OV HMO	KAISE	<i>R</i> : □	\$10 OV HMO	
□ \$20 OV HMO			\$30 OV HMO	
□ \$500DHMO			\$1000DHMO	
☐ H.S.A.\$1500			H.S.A.\$3000	
BLUE SHIELD:				
☐ 100% PPO	BLUE SH		90% PPO	
□ 80% PPO			H.S.A.\$1500	
H.S.A.\$3000			2-Tier H.S.A.S	\$5000
2-Tier MEC\$9000			WABE (Waiv	er of Active Benefit Enrollment)
ELIGIBILITY CHANGES				
Please Complete a SISC Membership Change Form  TEDMINATE COVEDACE				

TERMINATE COVERAGE

Please complete a SISC Term MAR