

Full District Name: _____ **Client ID:** _____

SISCconnect Administrators will individually e-mail each added user their unique SISCconnect login credentials (*User Name and Temporary Password*) upon account creation. Each user must follow the instructions in the e-mail in order to gain access into SISCconnect. When a user logs into SISCconnect for the first time, they will be prompted to create a new password.

Change Options
(Select one for each user)

Contact Information

Primary Contact: One person at district primarily responsible for SISC benefit administration

Contact Type: Finance/Billing HR Broker/Consultant Superintendent

Name: _____

E-mail Address: _____

Phone Number: _____ **Extension (if applicable):** _____

ADD USER
UPDATE NAME
UPDATE E-MAIL
REMOVE USER

Contact Type: Finance/Billing HR Broker/Consultant Superintendent

Name: _____

E-mail Address: _____

Phone Number: _____ **Extension (if applicable):** _____

ADD USER
UPDATE NAME
UPDATE E-MAIL
REMOVE USER

Contact Type: Finance/Billing HR Broker/Consultant Superintendent

Name: _____

E-mail Address: _____

Phone Number: _____ **Extension (if applicable):** _____

ADD USER
UPDATE NAME
UPDATE E-MAIL
REMOVE USER

Contact Type: Finance/Billing HR Broker/Consultant Superintendent

Name: _____

E-mail Address: _____

Phone Number: _____ **Extension (if applicable):** _____

ADD USER
UPDATE NAME
UPDATE E-MAIL
REMOVE USER

Contact Type: Finance/Billing HR Broker/Consultant Superintendent

Name: _____

E-mail Address: _____

Phone Number: _____ **Extension (if applicable):** _____

ADD USER
UPDATE NAME
UPDATE E-MAIL
REMOVE USER

Please submit additional signed SISCconnect registration form(s) if you need to authorize additional users. **Forms submitted without Authorized District Administrator signature cannot be processed due to system security requirements.**

Authorized Signature (District Administrator (Director or higher), Superintendent, HR Director, CBO):

Signature: _____ **Name:** _____

Title: _____ **Date:** _____

Registration Prepared By: _____ **Date:** _____

Phone: _____ **E-mail Address:** _____

With the electronic signature above, the individual is affirming he or she is duly authorized under state and federal law (including, but not limited to, HIPAA) to approve the SISCconnect user adjustments listed on this form. The individual (a) understands the added users listed above will receive full access to all reports, eligibility information, eligibility submissions, and member data (including, but not exclusive, to: Social Security Numbers, plan details, addresses, etc.) associated with the district listed in this document and (b) represents that those added users have been duly designated by District as authorized under HIPAA to have such access and such users will comply with HIPAA and all other applicable laws. At any time should the district require an update to the list of approved users, it is the responsibility of the district to inform SISC of these changes and complete this form accordingly.