2017-18 Personal Data Change Form

The Local Choice Program

Instructions: Please print clearly. Complete Participant Information and then only those items to be changed. Your Benefits Administrator may require documentation before approving changes. Documentation is always required for Social Security Number changes.

Participant Information:

Health Plan ID (or Social Security Number) shown on your identification card: _____

Name shown on your identification card: _____ _____ _____
First Name MI Last Name

Date these changes are effective: Month: _____ Day: _____ Year: _____

☐ **Change my Name:** _____ _____ _____ _____
First Name MI Last Name Suffix: (Jr, Sr, III)

☐ **Change my Address:** Street or PO Box: _____

City: _____State: _____Zip+4: _____ - _____

☐ **Change my Phone Number(s):** Work Phone: ( ) _____ - _____ Personal Phone: ( ) _____ - _____

☐ **Change my Email(s):** Email: _____

☐ **Change my Date of Birth / Gender:** Month: _____ Day: _____ Year: _____ ☐ Female ☐ Male

☐ **Change my covered Dependent's Personal Data:** (Codes: H=Husband, W=Wife, D=Daughter, S=Son, SD=Step-Daughter, SS=Stepson)

Code:	First Name	Middle Initial	Last Name, Suffix (Jr, Sr, II, III)	Date of Birth (MM/DD/YYYY)	Social Security Number (NNN-NN-NNNN)
____	_____	_____	_____	_____ / _____ / _____	_____-_____-_____
____	_____	_____	_____	_____ / _____ / _____	_____-_____-_____

Your Signature:_____**Date:**_____

Return this completed from to your employer's benefits administrator.

Authorization of Employer's Benefits Administrator:

☐ I certify that the information on this form and in the required supporting documentation is complete and accurate to the best of my knowledge.

Date Sent to DHRM: Month:_____Day:_____Year:_____ TLC Group Number:_____-_____-_____

Authorized by: Name:_____Phone: ( )_____-_____

Send authorized form by: Email: TLC@dhrm.virginia.gov, Fax: (804) 786-1708, or Mail: DHRM – TLC, 101 N 14th St Fl 13, Richmond, VA 23219