2016-17 TLC Personal Data Change Form

Instructions: Please print clearly. Complete Member Information and then only those items to be changed.
For Social Security Number corrections, attach documentation.

Member 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