

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