



2019-20 Personal Data Change Form

The Local Choice Program

Instructions: Please print or type legibly - illegible forms will delay processing.
Complete Participant (Subscriber) 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 (Subscriber) Information:

Subscriber ID (or Social Security Number): _____

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: Please make sure this form is legible - illegible forms will delay processing.

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: _____ DHRM 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