



# 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 form 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](mailto:TLC@dhrm.virginia.gov), Fax: (804) 786-1708, or Mail: DHRM – TLC, 101 N 14<sup>th</sup> St Fl 13, Richmond, VA 23219