**2016-17 TLC Group Data Change Form** 

Group/Subdivision Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DHRM Group Number: Agy:\_\_\_\_\_\_Grp:\_\_\_\_\_\_Sub\_\_\_\_\_\_

1. **🞏Change Mailing Address.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Street or P O Box: |  | Suite: |  |
|  |  |  |  |  |  |
| City: |  | State: |  | Zip+4: |  |

1. **🞏Change Shipping Address (physical location).**  🞏Shipping Address same as Mailing Address

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Street or P O Box: |  | Suite: |  |
|  |  |  |  |  |  |
| City: |  | State: |  | Zip+4: |  |

1. **🞏Change Benefits Administrator’s information.** This person handles eligibility and enrollment, and has primary access to HuRMan.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| First Name: |  | Middle Initial: |  | Last Name: | Suffix: |  |  |
|  |  |  |  |  |  |  |  |
| Title: |  | Nickname: |  |
|  |  |  |  |  |  |  |  |
| Phone: | ( ) -  | Ext: |  | Fax: | ( ) -  |  |  |
|  |  |  |  |  |  |  |  |
| Email: |  | ID or SSN: |  |

1. **🞏Change Benefits Executive’s information.** This person authorizes the renewal.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| First Name: |  | Middle Initial: |  | Last Name: | Suffix: |  |  |
|  |  |  |  |  |  |  |  |
| Title: |  | Nickname: |  |
|  |  |  |  |  |  |  |  |
| Phone: | ( ) -  | Ext: |  | Fax: | ( ) -  |  |  |
|  |  |  |  |  |  |  |  |
| Email: |  | ID or SSN: |  |

1. **🞏Change Billing Administrator’s information.** This person receives and handles inquiries about billing.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| First Name: |  | Middle Initial: |  | Last Name: | Suffix: |  |  |
|  |  |  |  |  |  |  |  |
| Title: |  | Nickname: |  |
|  |  |  |  |  |  |  |  |
| Phone: | ( ) -  | Ext: |  | Fax: | ( ) -  |  |  |
|  |  |  |  |  |  |  |  |
| Email: |  | ID or SSN: |  |

1. **🞏Change Billing Executive’s information.** This person authorizes premium payments.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| First Name: |  | Middle Initial: |  | Last Name: | Suffix: |  |  |
|  |  |  |  |  |  |  |  |
| Title: |  | Nickname: |  |
|  |  |  |  |  |  |  |  |
| Phone: | ( ) -  | Ext: |  | Fax: | ( ) -  |  |  |
|  |  |  |  |  |  |  |  |
| Email: |  | ID or SSN: |  |

1. **Employer Certification.** I certify that the information on this form is complete and accurate to the best of my knowledge. 🞏Yes 🞏No

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Signature: |  |  | Date Signed (MM/DD/YYYY): |  |
|  |  |  |  |  |  |  |  |
| Printed Name: |  | Phone: | ( ) - | Ext: |  |
|  |  |  |  |  |  |  |
| Title: |  | Date sent to DHRM (MM/DD/YYYY): |  |