2020-21 Group Data Change Form

The Local Choice Program

Instructions: Please print or type legibly – illegible forms will delay processing.
Complete only the items to be changed. Contact changes require the ID or SSN and date of birth.

Group/Subdivision Name: ____ **DHRM Group Number:** ______-______-______

1. ☐ **Change Mailing Address.**			
Street or P O Box:			Suite:
City:		State:	Zip+4:
2. ☐ **Change Shipping Address (physical location).** ☐ Shipping Address same as Mailing Address.			
Street or P O Box:			Suite:
City:		State:	Zip+4:
3. ☐ **Change Benefits Administrator's information.** This person handles eligibility and enrollment.			
First Name:	Middle Initial:	Last Name:	Suffix:
ID or SSN:		Date of Birth:	
Email:			
Phone: ( ) -	Ext:	Fax: ( ) -	
4. ☐ **Change Benefits Executive's information.** This person authorizes the renewal.			
First Name:	Middle Initial:	Last Name:	Suffix:
ID or SSN:		Date of Birth:	
Email:			
Phone: ( ) -	Ext:	Fax: ( ) -	
5. ☐ **Change Billing Administrator's information.** This person receives and handles inquiries about billing.			
First Name:	Middle Initial:	Last Name:	Suffix:
ID or SSN:		Date of Birth:	
Email:			
Phone: ( ) -	Ext:	Fax: ( ) -	
6. ☐ **Change Billing Executive's information.** This person authorizes premium payments.			
First Name:	Middle Initial:	Last Name:	Suffix:
ID or SSN:		Date of Birth:	
Email:			
Phone: ( ) -	Ext:	Fax: ( ) -	
7. **Employer Certification.** I certify that the information on this form is complete and accurate to the best of my knowledge. ☐ Yes ☐ No			
Date sent to DHRM: Month:	Day:	Year:	DHRM Group Number: - -
Authorized by: Name:			Phone: ( ) - Ext:

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