Group Adjustment Form

The Local Choice Program

Instructions: Please print or type legibly – illegible forms will delay processing.

Use this form to terminate coverage for a participant (subscriber). Remember, participants (subscribers) are employees, retirees, survivors, and extended coverage/COBRA qualified beneficiaries. When you terminate coverage for a participant (subscriber), all covered family members are automatically terminated. Be sure to process terminations timely.

Note: If the participant (subscriber) is enrolling in COBRA or Retiree coverage, do not use this form. Use the TLC Enrollment Form. By checking "Initial Enrollment" on the enrollment form, the prior coverage is terminated. Do not submit both forms.

Action Code	Participant (Subscriber) ID or SSN	Participant (Subscriber) Last Name	Participant (Subscriber) First Name	Event Date MM/DD/YYYY	Term Date MM/DD/YYYY

Action Code:

T1 Terminate coverage – Participant (subscriber) is no longer eligible.
Use the last day eligible for coverage as the Event Date and the end of that month as the Term Date.
For example, if the last day worked is 3/25/XX, use 3/25/XX as the Event Date and 3/31/XX as the Term Date.
Coverage always ends the last day of a month.

T2 Terminate coverage - Death of participant (subscriber).
Use date of death as Event Date and the end of that month as the Term Date. If coverage is provided to survivors for one extra month, use the end of that month as the Term Date.

Group Authorization: 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