



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. <input type="checkbox"/> Change Mailing Address.			
Street or P O Box:		Suite:	
City:	State:	Zip+4:	
2. <input type="checkbox"/> Change Shipping Address (physical location). <input type="checkbox"/> Shipping Address same as Mailing Address.			
Street or P O Box:		Suite:	
City:	State:	Zip+4:	
3. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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