**Personal Data Changes Form**

Complete Participant Information Section and then only those items to be changed. Your HR Administrator may require documentation before approving changes. Documentation is always required for Social Security Number changes and Name Changes.

Prior to submitting, verify the information being provided is compliant with existing Commonwealth
and/or agency policies.

*Please print legibly to prevent delay in processing.*

|  |
| --- |
| **Participant Information** |
| Employee ID |  |
| First Name |  |
| Middle Name |  |
| Last Name |  |
| Effective Date (MM/DD/YYYY) |  |

**Change Address**

*To save United States addresses, Address 1 must be populated. Address 2 & Address 3 are optional.*

|  |
| --- |
| **Home Address Information** |
| Country |  |
| Address 1 |  |
| Address 2 |  |
| Address 3For Foreign Addresses Only |  |
| City |  |
| State |  |
| Zip (Postal) |  |
| County |  |
| **Mailing Address Information**  |
| Same as Home Address |[ ]
| Country |  |
| Address 1 |  |
| Address 2 |  |
| Address 3For Foreign Addresses Only |  |
| City |  |
| State |  |
| Zip (Postal) |  |
| County |  |

**Change Contact Details**

**Change my Phone Number:**

|  |
| --- |
| **Phone Number Information** |
| Add Number or Edit Number*(choose one)* |  |
| Type | [ ]  Home [ ]  Mobile |
| Preferred | [ ]  Yes [ ]  No |
| Number |  |
| Extension |  |

**Change my Personal Email:**

|  |
| --- |
| **Email Information** |
| Add Email or Edit Email*(choose one)* |  |
| Preferred*(choose one)* | [ ]  Yes [ ]  No |
| Email Address |  |

**Change my Name:** *(supporting documentation necessary)*

|  |
| --- |
| **Name Information** |
| Change As Of(MM/DD/YYYY) | MM/DD/YYYY |
| Name Format |  |
| Name Prefix |  |
| First Name*As shown on your identification card* |  |
| Middle Name*As shown on your identification card* |  |
| Last Name*As shown on your identification card* |  |
| Name Suffix*`* |  |

**Change my Ethnic Group:**

|  |
| --- |
| **Ethnic Group Information** |
| Add New or Edit Existing |  |
| Ethnic Group |  |

**Change my Emergency Contact:**

|  |
| --- |
| **Emergency Contact Information** |
| Add New or Edit Existing |  |
| Contact Name |  |
| Relationship |  |
| Add Address*(choose one)* | [ ]  Yes [ ]  No |
| Same as mine*(choose one)* | [ ]  Yes [ ]  No |
| Country |  |
| Address 1 |  |
| Address 2 |  |
| Address 3 |  |
| City |  |
| State |  |
| Zip (Postal) |  |
| County |  |
| Add New or Edit Existing Phone Number |  |
| Same as mine*(choose one)* | [ ]  Yes [ ]  No |
| Type |  |
| Number |  |
| Extension |  |

**Change Additional Personal Information**

 **Change my Preferred Gender & Pronoun:**

|  |
| --- |
| **Preferred Gender & Pronoun** |
| Preferred Gender*(choose one)* | ☐ Male [ ]  Female [ ]  Non-Binary |
| Preferred Pronoun*(choose one)* | [ ]  She/Her [ ]  He/Him [ ]  They/Them |

**Change my Date of Birth:** *(supporting documentation necessary)*

|  |
| --- |
| **Changing Date of Birth** |
| Date of Birth(MM/DD/YYYY) |  |

**Change my Disability Status:**

|  |
| --- |
| **Disability Status** |
| Yes, I have a Disability (or previously had a disability)(choose one) | [ ]  Yes [ ]  No |
| No, I don’t have a disability(choose one) | [ ]  Yes [ ]  No |
| I do not wish to answer(choose one) | [ ]  Yes [ ]  No |

**Change my covered Dependent’s Personal Data**

|  |
| --- |
| **Dependent Information** |
| First Name |  |
| Middle Initial |  |
| Last Name |  |
| Suffix(*Jr, Sr, II)* |  |
| Date of Birth(MM/DD/YYYY) |  |
| Gender |  |
| Relationship to Employee (Dependent 1) |  |
| Marital Status |  |
| Student(choose one) | [ ]  Yes [ ]  No |
| Disabled(choose one) | [ ]  Yes [ ]  No |
| Address |  |
| Social Security Number |  |
| Phone Number |  |
| Email |  |

|  |
| --- |
| **Additional Dependent *(Optional)*** |
| First Name |  |
| Middle Initial |  |
| Last Name |  |
| Suffix(*Jr, Sr, II)* |  |
| Date of Birth(MM/DD/YYYY) |  |
| Gender |  |
| Relationship to Employee (Dependent 2) |  |
| Marital Status |  |
| Student(choose one) | [ ]  Yes [ ]  No |
| Disabled(choose one) | [ ]  Yes [ ]  No |
| Address |  |
| Social Security Number |  |
| Phone Number |  |
| Email |  |

**Your Signature: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Return this completed form to your employer’s HR administrator.**

*------------------------------Complete this page if you belong to the TLC program--------------------------------------*

**Authorization of Employer’s Benefits Administration:** 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
Mail: DHRM – TLC, 101 N 14th St Fl 13, Richmond, VA 23219