TLC 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. When you terminate coverage for a participant (subscriber), all covered family members are automatically terminated. Be sure to request terminations timely.

Action Code	Participant (Subscriber) Cardinal 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 due to Resignation – Participant (subscriber) is no longer eligible.

T2: Terminate coverage due to Retirement – Participant (subscriber) is no longer eligible for active coverage**.**

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.

T3: Terminate coverage due to Death of participant (subscriber).

Use date of death as Event Date and 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, Main Street Centre, 600 East Main St, 17th FL, Richmond, VA 23219