PTC Corporate Coverage Group
Delivering Employee Benefits & Enterprise Risk Solutions
Phone: 412-992-2855 Secure Fax: 412-535-0720
Email: msever@ptc-ccg.org

Enrollment and Change Form

Form Instructions:
New hires: Complete the form in its entirety.
Changes: Complete section I and any pertinent information in Section II.

	Individual	Employee + Child(ren)	Employee + Spouse	Family
Medical				
Dental				x
Vision				x

Carrier(s): ☐ Highmark Medical ☑ Highmark Vision ☑ UCCI Dental ☐ VBA Vision
Description: _____ _____ _____ _____

I. Employee/Applicant Information

Effective Date: 10/1/13
Employer Name: SpiralGen, Inc.
Client Code: (as appears on invoice)

Reason for Application
☑ New Employee
☐ Termination Date:
☐ Changes
☐ COBRA Start Date: End Date:
☐ Act 4
☐ Qualifying Event

Employee Name: (First, Middle, Last) Jason M. Larkin
Phone Number: 412-398-8813

Street Address: (Address, City, State, Zip) 4763 Sherwood Dr., Pittsburgh, PA 15236

Marital Status: (please check) ☐ Single ☑ Married ☐ Widowed ☐ Divorced
Employment Status: (please check): ☑ Active ☐ COBRA ☐ Disabled
Date of Hire: 10/7/2013
Full Time: x
Part Time:
Hours Worked per Week: 40

Job Title: Software Engineer
Salary:
Annual Salary/ HR Rate:
Email Address: jason.larkin@spiralgen.com

II. Covered Dependent Enrollment/Change Information

Dependent Relationship	First Name / Middle Initial/last Name	Social Security Number	Birth Date Mon	Day	Yr	Sex M / F	Enrollment Changes: Dependent Changes*	Other Changes**
☑ Self	Jason M. Larkin	208-68-1636				M		
☑ Spouse	Jodi R. Larkin	162-66-4921				F		
☑ Child	Charlotte R. Larkin	819-61-7624				F		
☑ Child	Fiona R. Larkin	210-85-0998				F		
☐ Child								

* Please indicate in the Dependent Changes column if the change is the result of a marriage, divorce, death, adoption or other. **Please indicate in the Other Changes column if this is a name change, address change, or a change in coverage.

I hereby certify that the information provided is accurate.
Employee Signature: _____

III. Waiver Information (Complete only if you Wish to Decline Coverage)

For: (check) ☐ Medical ☐ Dental ☐ Vision

I herby decline coverage for: (check)
☐ Myself ☐ For myself and ALL family members ☐ For family members only

Check if you have coverage elsewhere: ☐

If checked: Where do you have other coverage:

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/ or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a qualifying event occurs before coverage will be offered. I understand by waiving the above coverage I acknowledge that I am waiving COBRA rights for the individuals whose coverage is hereby waived.

Employee Signature: _____

Employer Signature: _____