☐ NEW ENROLLMENT
☐ CHANGE
☐ CONVERSION TO NON-GROUP

PARAMOUNT CARE OF MICHIGAN

ENROLLMENT APPLICATION

106 PARK PLACE
DUNDEE, MI 48131
(734) 529-7800 • FAX (734) 529-8896

PLEASE PRINT OR TYPE • PLEASE DO NOT WRITE IN SHADED AREAS • USE BALL POINT PEN AND PRESS HARD • MAKE SURE APPLICATION IS SIGNED AND DATED

SUBSCRIBER

PREVIOUS MEMBERSHIP WITH PARAMOUNT? ☐ YES ☐ NO IF YES, GIVE NAME AND ID #____________________

☐ CHANGE NAME
PREVIOUS NAME ____________________
☐ CHANGE SUBSCRIBER ADDRESS/PHONE
☐ CHANGE SUBSCRIBER PHYSICIAN

SOCIAL SECURITY NUMBER	LAST NAME	FIRST	MIDDLE

SUBSCRIBER STREET ADDRESS	CITY	STATE	CO.	ZIP CODE

HOME TELEPHONE	WORK TELEPHONE	EMAIL ADDRESS	DATE OF HIRE

* NOTE, IF CHANGING TO FULL-TIME EMPLOYEE STATUS OR IF RECALLED FROM LAYOFF, SPECIFY NEW DATE

BIRTH DATE	SEX	TOBACCO	PRIMARY CARE PHYSICIAN NAME	PHYSICIAN ID NUMBER	WILL YOU BE A NEW PATIENT FOR THIS PHYSICIAN?
_ _	☐ M ☐ F	☐ YES ☐ NO			☐ YES ☐ NO

GROUP NUMBER: ____________
DIVISION NUMBER: ____________

EFFECTIVE DATE

PREFERRED SPOKEN LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ SIGN ☐ OTHER: ____________

RACE (MARK ALL THAT APPLY): ☐ WHITE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/ PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE

ETHNIC BACKGROUND: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC/LATINO

DEPENDENTS

☐ ADD DEPENDENT -- ☐ DEPENDENT CHANGE OF PHYSICIAN
IF ADDING SPOUSE, MARRIAGE DATE ____________________

LAST NAME / FIRST / MIDDLE	BIRTH DATE	SEX	RELATIONSHIP	TOBACCO	RACE & ETHNICITY	PRIMARY CARE PHYSICIAN NAME / ID	NEW PATIENT
DEPENDENT SOCIAL SECURITY NO.	/ /	☐ M ☐ F	☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER	❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI ❑ HISP/LATINO ❑ NOT HISP/LAT		❑ YES ❑ NO
DEPENDENT SOCIAL SECURITY NO.	/ /	☐ M ☐ F	☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER	❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI ❑ HISP/LATINO ❑ NOT HISP/LAT		❑ YES ❑ NO
DEPENDENT SOCIAL SECURITY NO.	/ /	☐ M ☐ F	☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER	❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI ❑ HISP/LATINO ❑ NOT HISP/LAT		❑ YES ❑ NO
DEPENDENT SOCIAL SECURITY NO.	/ /	☐ M ☐ F	☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER	❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI ❑ HISP/LATINO ❑ NOT HISP/LAT		❑ YES ❑ NO
DEPENDENT SOCIAL SECURITY NO.	/ /	☐ M ☐ F	☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER	❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI ❑ HISP/LATINO ❑ NOT HISP/LAT		❑ YES ❑ NO

COMPLETE IF ENROLLING DEPENDENT REQUIRES LANGUAGE ASSISTANCE
DEPENDENT(S) FIRST NAME & LANGUAGE/FORMAT/DEVICE

OTHER INSURANCE

ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN? ☐ YES ☐ NO IF YES, COMPLETE OTHER INSURANCE SECTION.
ARE YOU OR ANY DEPENDENTS COVERED BY MEDICARE? ☐ YES ☐ NO

POLICY HOLDER NAME	BIRTHDATE OF POLICY HOLDER	EFFECTIVE DATE	END DATE	TYPE OF COVERAGE ☐ SINGLE ☐ FAMILY

INSURANCE CO.	POLICY NUMBER	FAMILY MEMBERS COVERED

INSURANCE COMPANY ADDRESS: ____________________ PHONE: ____________
CHECK ALL THAT APPLY: ☐ MEDICAL ☐ DRUG ☐ VISION ☐ DENTAL

MEDICARE PART A EFFECTIVE DATE: ____________ MEDICARE PART B EFFECTIVE DATE: ____________ PRESCRIPTION DRUG PLAN EFFECTIVE DATE: ____________
☐ DISABLED ☐ OVER AGE 65 ☐ END STAGE RENAL DISEASE PRIMARY MEMBER MEDICARE NO. ____________________

AGREEMENT

AGREEMENT: ON BEHALF OF MYSELF AND MY ELIGIBLE DEPENDENTS, I UNDERSTAND THAT MY ENROLLMENT AND BENEFITS ARE IN ACCORDANCE WITH THOSE DESCRIBED IN THE PARAMOUNT GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT (GSA). I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM MY EMPLOYER. I AGREE TO CHOOSE A PARTICIPATING PARAMOUNT CARE OF MICHIGAN PHYSICIAN FOR PRIMARY CARE AND TO SECURE A REFERRAL FROM THAT PHYSICIAN FOR ALL CARE (EXCEPT FOR EMERGENCIES AND OB/GYN CARE). I AGREE TO MAKE DIRECTLY TO THE PROVIDERS OF HEALTH CARE SUCH COST SHARINGS AS ARE PROVIDED FOR IN THE MEMBER HANDBOOK. I AUTHORIZE ANY HEALTH PROVIDER OR THIRD-PARTY PAYOR TO FURNISH PARAMOUNT CARE OF MICHIGAN OR ITS DESIGNATED AGENT ANY RECORDS CONCERNING ME OR ANY MEMBER OF MY FAMILY FOR WHOM INFORMATION IS REQUESTED. I FURTHER AUTHORIZE PARAMOUNT TO RELEASE THIS INFORMATION TO OTHER THIRD-PARTY PAYORS, GOVERNMENTAL AGENCIES, PRIVATE ACCREDITATION AGENCIES OR OTHER ENTITIES AUTHORIZED BY PARAMOUNT CARE OF MICHIGAN TO CONDUCT PROGRAM LICENSURE, CERTIFICATION OR ACCREDITATION SURVEYS, PROGRAM REVIEW OR FRAUD INVESTIGATION ACTIVITIES. I AUTHORIZE PARAMOUNT CARE OF MICHIGAN TO EXCHANGE CLINICAL INFORMATION ON ME OR MY DEPENDENTS WITH PROVIDERS TO FACILITATE CARE. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL AND SHALL CONTINUE IN EFFECT AS LONG AS I AM A PARAMOUNT SUBSCRIBER. I SHALL COOPERATE AND ASSIST PARAMOUNT CARE OF MICHIGAN IN THE EXERCISE OF ITS SUBROGATION AND COORDINATION OF BENEFITS RIGHTS INCLUDING AS AGAINST MY OWN OR OTHER PAYORS. I AGREE TO SUBMIT ANY DISPUTES WITH PARAMOUNT CARE OF MICHIGAN THROUGH THE GRIEVANCE PROCEDURE SET FORTH IN THE PARAMOUNT GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. IF APPROPRIATE, I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY WAGES THE AMOUNT REQUIRED (IF ANY) TO COVER MY CONTRIBUTION FOR COVERAGE. ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST HEALTH PLAN, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD UNDER MICHIGAN CRIMINAL LAW. IF, AFTER SIGNING THIS APPLICATION, YOU DECIDE TO CANCEL THIS AGREEMENT, YOU MAY DO SO BY SENDING A LETTER WITHIN SEVENTY-TWO (72) HOURS TO PARAMOUNT CARE OF MICHIGAN AT THE ABOVE ADDRESS. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT.

SUBSCRIBER SIGNATURE X ____________________ DATE ____________

SPOUSE SIGNATURE X ____________________ DATE ____________

EMPLOYER

CHECK ONE
▯ NEW GROUP ▯ RECALLED FROM LAYOFF
▯ NEW EMPLOYEE
▯ OPEN ENROLLMENT
▯ PART-TIME TO FULL-TIME

GROUP CONTINUATION OR INDIVIDUAL CONVERSION
QUALIFYING EVENT ____________________
▯ STATE OF MICHIGAN - CONVERSION
▯ COBRA
▯ 18 MOS. ▯ 36 MOS.
EFFECTIVE ____________________

COVERAGE WILL BE EFFECTIVE IN ACCORDANCE WITH THE ENROLLMENT ELIGIBILITY POLICY ESTABLISHED BETWEEN THE GROUP AND PARAMOUNT.

EMPLOYER SIGNATURE X ____________________

EMPLOYER SIGNATURE X ____________________ SIGNATURE DATE ____________ EFFECTIVE DATE ____________

Part One - Paramount Health Care / Part Two - Employer Copy / Part Three - Subscriber Copy