☐ NEW ENROLLMENT
☐ CHANGE

PARAMOUNT
Insurance Company

ENROLLMENT APPLICATION

P.O. BOX 928
TOLEDO, OHIO 43697-0928
(419) 887-2525
1-800-462-3589

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

SOCIAL SECURITY NUMBER	LAST NAME	FIRST	MIDDLE

STREET ADDRESS	CITY	STATE	CO.	ZIP CODE

HOME TELEPHONE	WORK TELEPHONE	DATE OF HIRE	* NOTE, IF CHANGING TO FULL-TIME EMPLOYEE STATUS OR IF RECALLED FROM LAYOFF, SPECIFY NEW DATE

BIRTH DATE	SEX	TOBACCO	EMAIL ADDRESS
	☐ M ☐ F	☐ 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
IF ADDING SPOUSE, MARRIAGE DATE ____________

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

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
ARE YOU OR ANY DEPENDENTS COVERED BY MEDICARE? ☐ YES ☐ NO
IF YES, COMPLETE THIS SECTION.

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: I UNDERSTAND AND AGREE THAT MY ENROLLMENT AND BENEFITS ARE IN ACCORDANCE WITH THE TERMS DESCRIBED IN MY PARAMOUNT INSURANCE POLICY. I AGREE TO MAKE DIRECTLY TO THE PROVIDERS OF HEALTH CARE SUCH CO-PAYMENTS, COINSURANCE OR DEDUCTIBLES AS PROVIDED FOR IN THE (COI) INSURANCE POLICY. PARAMOUNT IS A COVERED ENTITY UNDER HIPAA AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROTECTED HEALTH INSURANCE (PHI) TO PERFORM PARAMOUNT OPERATIONS IN ACCORDANCE WITH PARAMOUNT NOTICE OF PRIVACY PRACTICES. I SHALL COOPERATE AND ASSIST PARAMOUNT IN THE EXERCISE OF ITS SUBROGATION AND COORDINATION OF BENEFITS RIGHTS (IF APPLICABLE) INCLUDING AS AGAINST MY OWN OR OTHER PAYORS AS SET FORTH IN THE INSURANCE POLICY. I AGREE TO PURSUE ANY DISPUTES WITH PARAMOUNT THROUGH THE GRIEVANCE PROCEDURE SET FORTH IN MY PARAMOUNT (COI) INSURANCE POLICY. IF APPROPRIATE, I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY WAGES THE AMOUNT REQUIRED (IF ANY) TO COVER MY CONTRIBUTION FOR COVERAGE. IF APPROPRIATE, I AGREE TO THE PERIODIC PAYMENT OF PREMIUM RATES WHEN DUE. IF, AFTER SIGNING THIS APPLICATION, I DECIDE TO RESCIND MY POLICY, I UNDERSTAND I MAY DO SO BY RETURNING THE POLICY TO PARAMOUNT BY MAIL OR PERSONAL DELIVERY WITHIN 10 DAYS AFTER THE DATE I RECEIVED IT. PARAMOUNT WILL REFUND ANY PREMIUM I HAVE PAID, THIS POLICY WILL THEN BE CONSIDERED NEVER TO HAVE BEEN ISSUED. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT.

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURANCE COMPANY, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

INSURED SIGNATURE X ____________________ DATE ____________

SPOUSE SIGNATURE X ____________________ DATE ____________

EMPLOYER

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

COMPANY NAME X ____________________

GROUP CONTINUATION
QUALIFYING EVENT ____________________
☐ STATE OF OHIO – 6 MONTHS
☐ COBRA
☐ 18 MOS. ☐ 29 MOS. ☐ 36 MOS.
EFFECTIVE ____________________

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

EMPLOYER SIGNATURE X ____________________ SIGNATURE DATE ____________ EFFECTIVE DATE ____________