☐ NEW ENROLLMENT
☐ CHANGE
☐ CONVERSION TO NON-GROUP

PARAMOUNT PreferredChoices

ENROLLMENT APPLICATION

P.O. BOX 928
TOLEDO, OHIO 43697-0928
(866) 380-8900

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

SUBSCRIBER STREET ADDRESS (IF P.O. BOX, MUST INCLUDE PHYSICAL ADDRESS OF RESIDENCE)	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 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 LISTED DEPENDENTS, I UNDERSTAND THAT MY ENROLLMENT AND BENEFITS ARE IN ACCORDANCE WITH THOSE DESCRIBED IN MY PARAMOUNT GROUP CERTIFICATE OF INSURANCE/COVERAGE. I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM PARAMOUNT OR MY EMPLOYER. 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'S NOTICE OF PRIVACY PRACTICES. I SHALL COOPERATE AND ASSIST PARAMOUNT IN THE EXERCISE OF ITS SUBROGATION AND COORDINATION OF BENEFITS RIGHTS INCLUDING AS AGAINST MY OWN OTHER PAYERS AS SET FORTH IN MY EMPLOYER'S CONTRACT WITH PARAMOUNT. I AGREE TO SUBMIT ANY DISPUTES WITH PARAMOUNT THROUGH THE GRIEVANCE PROCEDURE SET FORTH IN MY EMPLOYER'S CONTRACT WITH PARAMOUNT. 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 THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST PARAMOUNT, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD UNDER OHIO LAW. IF, AFTER SIGNING THIS APPLICATION, YOU DECIDE TO CANCEL THIS AGREEMENT, YOU MAY DO SO BY SENDING A CERTIFIED LETTER WITHIN SEVENTY-TWO (72) HOURS TO PARAMOUNT AT THE ABOVE ADDRESS. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT.

INSURED SIGNATURE X ________________ DATE ________________
SPOUSE SIGNATURE X ________________ DATE ________________

EMPLOYER

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

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 ________________

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