☐ NEW ENROLLMENT ☐ CHANGE

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

PARAMOUNT
Insurance Company

ENROLLMENT APPLICATION

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

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	EMAIL ADDRESS

DATE OF HIRE	* NOTE, IF CHANGING TO FULL-TIME EMPLOYEE STATUS OR IF RECALLED FROM LAYOFF, SPECIFY NEW DATE	BIRTH DATE	SEX ☐ M ☐ F	TOBACCO ☐ 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

☐ ADD DEPENDENT
IF ADDING SPOUSE, MARRIAGE DATE __________________

DEPENDENTS

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT SOCIAL SECURITY NO.			– –	❏ M ❏ F	❏ SPOUSE ❏ CHILD ❏ STEPCHILD ❏ OTHER

TOBACCO	RACE & ETHNICITY		
❏ YES ❏ NO	❏ W ❏ A ❏ B/AA ❏ AI/AN ❏ NH/PI	❏ HISP/LATINO ❏ NOT HISP/LAT	

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT SOCIAL SECURITY NO.			– –	❏ M ❏ F	❏ SPOUSE ❏ CHILD ❏ STEPCHILD ❏ OTHER

TOBACCO	RACE & ETHNICITY		
❏ YES ❏ NO	❏ W ❏ A ❏ B/AA ❏ AI/AN ❏ NH/PI	❏ HISP/LATINO ❏ NOT HISP/LAT	

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT SOCIAL SECURITY NO.			– –	❏ M ❏ F	❏ SPOUSE ❏ CHILD ❏ STEPCHILD ❏ OTHER

TOBACCO	RACE & ETHNICITY		
❏ 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

PLEASE CONTINUE ON REVERSE SIDE

DEPENDENTS

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT			– –	❑ M ❑ F	❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ OTHER
SOCIAL SECURITY NO.					

TOBACCO	RACE & ETHNICITY	
❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI	❑ HISP/LATINO ❑ NOT HISP/LAT

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT			– –	❑ M ❑ F	❑ SPOUSE ❑ CHILD ❑ STEPCHILD ❑ OTHER
SOCIAL SECURITY NO.					

TOBACCO	RACE & ETHNICITY	
❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI	❑ HISP/LATINO ❑ NOT HISP/LAT

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 OTHER INSURANCE SECTION.

OTHER INSURANCE

POLICY HOLDER NAME	BIRTHDATE OF POLICY HOLDER	EFFECTIVE DATE	END DATE
INSURANCE CO.	POLICY NUMBER	FAMILY MEMBERS COVERED	

TYPE OF COVERAGE
☐ SINGLE ☐ FAMILY

INSURANCE COMPANY ADDRESS: _____ PHONE: _____

CHECK ALL THAT APPLY:
☐ MEDICAL ☐ DRUG ☐ VISION ☐ DENTAL

MEDICARE PART A EFFECTIVE DATE: _____
☐ DISABLED ☐ OVER AGE 65 ☐ END STAGE RENAL DISEASE

MEDICARE PART B EFFECTIVE DATE: _____ PRESCRIPTION DRUG PLAN EFFECTIVE DATE: _____

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 UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE FROM PARAMOUNT UPON REQUEST. 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.

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

COMPANY NAME **X** _____

EMPLOYER SIGNATURE **X** _____

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

GROUP CONTINUATION
QUALIFYING EVENT _____
❑ STATE OF OHIO – 6 MONTHS
❑ COBRA
❑ 18 MOS. ❑ 29 MOS. ❑ 36 MOS.
EFFECTIVE _____
SIGNATURE DATE _____
EFFECTIVE DATE _____