□ NEW ENROLLMENT □ CHANGE

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



## **HMO 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 ☐ CHANGE SUBSCRIBER ☐ CHANGE SUBSCRIBER PHYSICIAN PREVIOUS NAME ADDRESS/PHONE REASON FOR PCP CHANGE   |                                      |                                 |  |                                |                          |  |                    |                      |                |
| SOCIAL SEC  | CURITY NUMBER                        | IE FIRS                         |  |                                | FIRST                    | MIDDLE                                     |                    |                      |                |
| SUBSCRIBE   | R STREET ADDRESS                     |                                 | CITY   |                                |                          |  | STATE              | CO.                  | ZIP CODE       |
| HOME TELEP  | HONE                                 | WO                              | PRK TELEPHONE  | PHONE EMAIL ADDI               |                          |  | RESS               |                      |                |
| DATE OF HIRE * NOTE, IF CHAN<br>OR IF RECALLE   |                                      |                                 | GING TO FULL-TIME EMPLOYEE STATUS BIRTH DAT<br>D FROM LAYOFF, SPECIFY NEW DATE |                                | H DATE                   | SEX 🗆 M 🗆 F                                | EX M F TOBACCO YES |                      |                |
| PRIMARY CA  | ARE PHYSICIAN NAME                   | I                               |  |                                | ILL YOU BE A<br>YES 🗌 NO | BE A NEW PATIENT FOR THIS PHYSICIAN?<br>NO |                    |                      |                |
|   | MBER:                                | ECTIVE DATE                     | PREFERRED SPOKEN LANGUA  |                                |                          |  | OTHER: _           |                      |                |
| RACE (MARK ALL THAT APPLY): WHITE ASIAN BLACK/AFRICAN AMERICAN ETHNIC BACKGROUND: HISPANIC OR LATINO NATIVE HAWAIIAN/ PACIFIC ISLANDER AMERICAN INDIAN/ALASKAN NATIVE |                                      |                                 |  |                                |                          |  |                    |                      |                |
| ☐ ADD DEPENDENT ☐ DEPENDENT CHANGE OF PHYSICIAN IF ADDING SPOUSE, MARRIAGE DATE REASON FOR PCP CHANGE   |                                      |                                 |  |                                |                          |  |                    |                      |                |
|   |                                      |                                 | DEPENDEN   |                                |                          |  |                    |                      |                |
| LAST NAME FIRST   |                                      |                                 | MIDDLE BIRTH DA  |                                | IRTH DATE                | SEX  |                    | LATIONSHIP           |                |
| DEPENDENT SOCIAL SECURITY NO.   |                                      |                                 | - ·  |                                |                          | 1  |                    | SE CHILD CHILD OTHER |                |
| TOBACCO   | O RACE & ETHNICITY NAME PRIMARY CA   |                                 |  | ARY CAR                        | E PH\                    | YSICIAN<br>ID                              | •                  | NEW PATIENT          |                |
|   | □W□A□B/AA□<br>□AI/AN□NH/PI□          | ☐ HISP/LATINO<br>☐ NOT HISP/LAT |  |                                |                          |  |                    | ا ا                  | YES 🗆 NO       |
| LAST N  | IAME                                 | FIRST                           | MIDD   | LE                             | В                        | IRTH DATE                                  | SEX                |                      | LATIONSHIP     |
| DEPENDEN  |                                      |                                 |  |                                |                          | □M   |                    | SE CHILD CHILD       |                |
| SOCIAL SECURITY NO.   |                                      |                                 |  |                                |                          |  |                    |                      |                |
| TOBACCO   | RACE & ET                            | _                               | NAME PRIMA   | PRIMARY CARE PHYSICIAN NAME ID |                          |  |                    | NE                   | EW PATIENT     |
|   | □W□A□B/AA□<br>□AI/AN□NH/PI□          |                                 |  |                                |                          |  |                    | ٦                    | YES □ NO       |
| LAST N  | IAME                                 | FIRST                           | MIDD   | LE                             | В                        | IRTH DATE                                  | SEX                | RE                   | LATIONSHIP     |
| DEPENDENT   |                                      |                                 |  |                                |                          |  | □M<br>□F           |                      | SE CHILD OTHER |
| SOCIAL SECURITY NO.   |                                      |                                 |  |                                |                          | W PATIENT                                  |                    |                      |                |
|   | UW UA UB/AA                          |                                 | NAME   | AIII OAII                      |                          | ID   |                    |                      |                |
|   | □ AI/AN □ NH/PI                      |                                 |  |                                |                          |  |                    |                      | YES □ NO       |
|   | IF ENROLLING DEF<br>S LANGUAGE ASSIS |                                 | EPENDENT(S) FIRST NAM  | E & LANG                       | GUAG                     | E/FORMAT/D                                 | DEVICE             |                      |                |
|   | PLEASE CONTINUE ON REVERSE SIDE      |                                 |  |                                |                          |  |                    |                      |                |

| DEPENDENT SOCIAL SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN DISTRICT SECURITY NAME PHYSICIAN D | DEPENDENTS  |  |                |                 |                               |            |                       |              |                 |  |  |
|--|---|--|----------------|-----------------|-------------------------------|------------|-----------------------|--------------|-----------------|--|--|
| TOBACCO RACE & ETHINICITY  NAME  PRIMARY CARE PHYSICIAN    YES   JAW   GAA   GAA   HISPAATNO   | LAST NAME FIRST   |  |                | MIDDLE          | BIRTH DATE                    |            | SEX                   | RELATIONSHIP |                 |  |  |
| TOBACCO  RACE & ETHNICITY NAME  PRIMARY CARE PHYSICIAN  DI JARA   JAHSPILATINO  DEPENDENT  LAST NAME  FIRST  MIDDLE  BIRTH DATE  SEX  RELATIONSHIP  DEPENDENT  COCIAL SECURITY NO.  TOBACCO  RACE & ETHNICITY NAME  PRIMARY CARE PHYSICIAN  DI JARA   JAHSPILATINO  DEPENDENT  TOBACCO  RACE & ETHNICITY NAME  PRIMARY CARE PHYSICIAN  DI JARA   JAHSPILATINO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   NO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   NO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   NO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   NO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   NO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   NO  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN?   YES   COMPLETE OTHER INSURANCE SECTION.  OTHER INSURANCE  POLICY HOLDER NAME  BIRTHDATE OF POLICY HOLDER  BIRTHDATE OF POLICY HOLDER  BIRTHDATE OF POLICY HOLDER  FAMILY MEMBERS COVERED  TYPE OF COVERAGE  SINGLE   FAMILY   MISURANCE COMPANY ADDRESS:  PHONE:  MEDICARE PART B EFFECTIVE DATE:  PRIMARY MEMBER MEDICARE NO.  AGREEMENT ON BEHAF OF MYSELF AND LISTED DEPENDENTS I LIDRESTAND THAI THAY PHY:  MEDICARE PART B EFFECTIVE DATE:  PRIMARY MEMBER MEDICARE NO.  AGREEMENT ON BEHAF OF MYSELF AND LISTED DEPENDENTS I LIDRESTAND THAI THAY PHY ORD THAY A CONTROLLED THAY |   |  |                |                 |                               |            |                       |              |                 |  |  |
| JYES   JAYA   JAHAP    JAYA   JAY    |   |  | THNICITY       |                 | PRIMARY CARE PHYSICIAN        |            |                       |              |                 |  |  |
| DEPENDENT SOCIAL SECURITY NO.  TOBACCO RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN D RACE & ETHNICITY NAME PRIMARY CARE PHYSICIAN D STEPCHILD DOTHER NEW PATIENT  ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN? DYES NO ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN? DYES NO ARE YOU OR ANY DEPENDENTS COVERED BY MEDICARE? SESSION OF PERSONAL PROPERTY OF THE INSURANCE PLAN? DYES NO ARE YOU OR ANY DEPENDENTS COVERED BY MEDICARE? SESSION OF PERSONAL PROPERTY OF THE INSURANCE PLAN? DYES NO  TYPE OF COVERAGE BIRTHDATE OF POLICY HOLDER BIRTHDATE OF POLICY HOLDER FAMILY MEMBERS COVERED  TYPE OF COVERAGE SINGLE FAMILY INSURANCE COMPANY ADDRESS: PHONE: MEDICAL DRUG VISION DENTAL DISABLED OF REPORT OF THE PROPERTY OF THE PROPE |   |  |                | NAME            |                               |            | ID                    |              | □ YES □ NO      |  |  |
| TORACCO   NACE & ETHNICITY   NAME   PRIMARY CARE PHYSICIAN   NEW PATIENT   NEW PATIENT   NAME   PRIMARY CARE PHYSICIAN   NEW PATIENT   NEW PATIENT   NAME   PRIMARY CARE PHYSICIAN   NEW PATIENT   NE  | LAST N  | IAME   | FIRST          |                 | MIDDLE                        | BIRTH      | DATE                  | SEX          | RELATIONSHIP    |  |  |
| TORACCO   RACE & ETHNICITY   NAME   PRIMARY CARE PHYSICIAN   NEW PATIENT   NEW PATIENT   NEW PATIENT   NAME   PRIMARY CARE PHYSICIAN   NEW PATIENT   NAME   PRIMARY MARKET   NAME   PRIMARY MARKET   NAME   PRIMARY MARKET   NAME   NAME   PRIMARY MARKET   NAME   NAME   PRIMARY MARKET   NAME   NAME  | DEPENDEN  | Т  |                |                 |                               |            |                       |              |                 |  |  |
| NAME   D   | SOCIAL SE   | CURITY NO.   |                |                 |                               | <u>D</u> F |                       |              | STEPCHILD OTHER |  |  |
| □ YES □ NO □ AIAN □ NIPIP □ NOT HISPILATINO □ AIR 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   BIRTHDATE OF POLICY HOLDER   EFFECTIVE DATE   END DATE  | TOBACCO   | RACE & E   | THNICITY       | NAME            | PRIMARY CARE PHYSICIAN        |            |                       |              |                 |  |  |
| OTHER INSURANCE  POLICY HOLDER NAME  BIRTHDATE OF POLICY HOLDER  BIRTHDATE OF POLICY HOLDER  FAMILY MEMBERS COVERED  INSURANCE CO.  POLICY NUMBER  FAMILY MEMBERS COVERED  TYPE OF COVERAGE  SINGLE  |   |  |                |                 |                               |            |                       |              | □ YES □ NO      |  |  |
| 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:  | DOLICY HOL  | DED NAME   |                |                 |                               |            |                       | -            | END DATE        |  |  |
| TYPE OF COVERAGE  SINGLE   FAMILY   INSURANCE COMPANY ADDRESS: PHONE:    MEDICAL THAT APPLY:   DECEMBER   MEDICARE PART A EFFECTIVE DATE: PRESCRIPTION DRUG PLAN EFFECTIVE PLAN EFFECTIVE DATE: PRESCRIPTION EFFECTIVE PLAN EFFECTIVE PLAN EFFECTIVE PLAN EFFECTIVE PLAN EFFECTIVE PLAN EFFECTIVE PLAN EFFECTIVE DATE: PROSCRIPTION EFFECTIVE PLAN EFFECTIVE PL | POLICY HOL  | DER NAME   |                | BIRTHDATE OF PC | EFFECTIVE DATE                |            |                       | END DATE     |                 |  |  |
| SINGLE  □ FAMILY  INSURANCE COMPANY ADDRESS:   | INSURANCE   | : CO.  |                | POLICY NUMBER   |                               | FAMILY     | MEMBERS               | S COVEREI    | )               |  |  |
| MEDICAL   DRUG   VISION   DENTAL   DISABLED   OVER AGE 65   END STAGE RENAL DISEASE  |   |  |                |                 |                               |            |                       | PHONE:       |                 |  |  |
| AGREEMENT: ON BEHALF OF MYSELF AND LISTED DEPENDENTS, I UNDERSTAND THAT MY ENROLLMENT AND BENEFITS ARE IN ACCORDANCE WITH THOSE DESCRIBED IN THE PARAMOUNT GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM PARAMOUNT OR MY EMPLOYER. I AGREE TO CHOOSE A PARTICIPATING PARAMOUNT PHYSICIAN FOR PRIMARY CARE. I AGREE TO MAKE DIRECTLY TO THE PROVIDERS OF HEALTH CARE SUCH CO-PAYMENTS AS ARE PROVIDED FOR IN THE MEMBER HANDBOOK. PARAMOUNT IS A COVERD ENTITY UNDER HPAD, AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROTECTED HEALTH INFORMATION (PHI) TO DEFRORM PARAMOUNT OPERATIONS IN ACCORDANCE WITH PARAMOUNTS 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 INCOPRIOR OF BENEFITS RIGHTS INCLIDING AS AGAINST MY OWN OTHER PRYORS AND AS FORTH OF THE MEMCAY. THE PARAMOUNT FIND THE PARAMOUNT FOR THE PARAMOUNT FOR PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE FROM PARAMOUNT IS THE EXERCISE OF ITS SUBROGATION AND COORDINATION OF BENEFITS RIGHTS INCLIDING AS AGAINST MY OWN OTHER PRYORS AND AS FORTH OF THE VIRE PROFILE OF THE SUBROGATION AND HOSPITAL SERVICE AGREEMENT I AGREE TO SUBMIT ANY DISPUTES WITH PARAMOUNT THROUGH THE GRIEVANCE PROCEDURE SET FORTH IN THE PARAMOUNT ROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT, I FAPPROPRIATE, I AUTHORIZE MY EMPLOYERS GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT, I FAPPROPRIATE, I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY WAGES THAT HE SHE IS ACLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS IS FACILITATING A FRAUD AGAINST HEALTH PLAN, SUBMITS AN 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.  SUBSCRIBER SIGNATURE X  DATE  CHECK ONE  GROUP CONTINUATION  UNLESS OF COVERAGE  DATE  STATE OF OHIO — 12 MONTHS  COMPANY NAME  |   |  |                |                 |                               |            |                       |              |                 |  |  |
| AGREEMENT: ON BEHALF OF MYSELF AND LISTED DEPENDENTS, I UNDERSTAND THAT MY ENROLLMENT AND BENEFITS ARE IN ACCORDANCE WITH THOSE DESCRIBED IN THE PARAMOUNT GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM PARAMOUNT PHYSICIAN OR FRIMARY CARE. I AGREE TO MAKE DIRECTLY TO THE PROVIDERS OF HEALTH CARE SUCH CO-PAYMENTS AS ARE PROVIDED FOR IN THE MEMBER HANDBOOK. PARAMOUNT IS A COVERED ENTITY UNDER HIPAA, AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROVIDED FOR IN THE MEMBER HANDBOOK. PARAMOUNT IS A COVERED ENTITY UNDER HIPAA, AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROVIDED FOR IN THE MEMBER HANDBOOK. PARAMOUNT IS A COVERED ENTITY UNDER HIPAA, AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROVIDED FOR IN THE MEMBER HANDBOOK. PARAMOUNT IS NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE FROM PARAMOUNT OPERATIONS IN ACCORDANCE WITH PARAMOUNTS NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I CAN OBTAIN A COPY OF THIS NOTICE FROM PARAMOUNT THE PARAMOUNT THE EXERCISE OF ITS SUBROGATION AND COORDINATION OF BENEFITS RIGHTS INCLUDING AS AGAINST MY OWN OTHER PAYORS AND AS SET FORTH IN MY EMPLOYERS GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I APPROPRIATE, I AUTHORIZE MY EMPLOYER GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. IF APPROPRIATE, I AUTHORIZE MY EMPLOYER FORM MY WAGES THE AMOUNT AGOUNT AND HOSPITAL SERVICE AGREEMENT. IN THE PARAMOUNT THROUGH THE GRIEVANCE PROCEDURE SET FORTH IN THE PARAMOUNT AND PERSON WITH INTENT TO DEFRAUD OR KNOWING THAT HESSEL IS FACILITATING A FRAUD AGAINST HEALTH PLAN, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS APPROPRIATE, I AUTHORIZE MY EMPLOYER TO DEFRAUD OR KNOWING TH |   |  |                |                 |                               |            |                       |              |                 |  |  |
| THOSE DESCRIBED IN THE PARAMOUNT GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM PARAMOUNT OR MY EMPLOYER. I AGREE TO CHOOSE A PARTICIPATING PARAMOUNT PHYSICIAN FOR PRIMARY CARE. I AGREE TO MAKE DIRECTLY TO THE PROVIDERS OF HEALTH CARE SUCH CO-PAYMENTS AS ARE PROVIDED FOR IN THE MEMBER HANDBOOK, PARAMOUNT IS A COVERED ENTITY UNDER HIPAA, AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROTECTED HEALTH INFORMATION (PHI) TO PERFORM PARAMOUNT OPERATIONS IN ACCORDANCE WITH PARAMOUNT'S 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 INCLUDING AS AGAINST MY OWN OTHER PAYORS AND AS SET FORTH IN MY EMPLOYERS GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I AGREE TO SUBMIT ANY DISPUTES WITH PARAMOUNT 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 HESHE SFACILITATING A FRAUD AGAINST HEALTH PLAN, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. 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.  SUBSCRIBER SIGNATURE X DATE  CHECK ONE  PART-TIME TO FULL-TIME (ATTACH HIPAA CERTIFICATE)  1 STATE OF OHIO — 12 MONTHS  1 SMOS. 129 MOS. 136 MOS.  EFFECTIVE  EMPLOYER SIGNATURE X SIGNATURE DATE  EMPLOYER SIGNATURE DATE  SIGNATURE DATE   |   |  |                | AGRE            | EMENT                         |            |                       | _            |                 |  |  |
| SPOUSE SIGNATURE X  EMPLOYER  CHECK ONE  NEW GROUP RECALLED FROM LAYOFF NEW EMPLOYEE OPEN ENROLLMENT LOSS OF COVERAGE PART-TIME TO FULL-TIME (ATTACH HIPAA CERTIFICATE)  COMPANY NAME X  EMPLOYER SIGNATURE X  DATE  GROUP CONTINUATION QUALIFYING EVENT STATE OF OHIO – 12 MONTHS COBRA 1 18 MOS. 29 MOS. 36 MOS. EFFECTIVE SIGNATURE DATE SIGNATURE DATE   | THOSE DESCRIBED IN THE PARAMOUNT GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM PARAMOUNT OR MY EMPLOYER. I AGREE TO CHOOSE A PARTICIPATING PARAMOUNT PHYSICIAN FOR PRIMARY CARE. I AGREE TO MAKE DIRECTLY TO THE PROVIDERS OF HEALTH CARE SUCH CO-PAYMENTS AS ARE PROVIDED FOR IN THE MEMBER HANDBOOK. PARAMOUNT IS A COVERED ENTITY UNDER HIPAA, AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROTECTED HEALTH INFORMATION (PHI) TO PERFORM PARAMOUNT OPERATIONS IN ACCORDANCE WITH PARAMOUNT'S 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 INCLUDING AS AGAINST MY OWN OTHER PAYORS AND AS SET FORTH IN MY EMPLOYER'S GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT. I AGREE TO SUBMIT ANY DISPUTES WITH PARAMOUNT 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 A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. 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 |  |                |                 |                               |            |                       |              |                 |  |  |
| CHECK ONE  NEW GROUP RECALLED FROM LAYOFF QUALIFYING EVENT STATE OF OHIO – 12 MONTHS COMPANY NAME  COMPANY NAME  EMPLOYER SIGNATURE STATE OF OHIO – 12 MONTHS COBRA SIGNATURE DATE SIGNATURE DATE SIGNATURE DATE SIGNATURE DATE SIGNATURE DATE   |   |  |                |                 |                               |            |                       |              |                 |  |  |
| CHECK ONE  NEW GROUP  RECALLED FROM LAYOFF  NEW EMPLOYEE  OPEN ENROLLMENT  PART-TIME TO FULL-TIME (ATTACH HIPAA CERTIFICATE)  COMPANY NAME  EMPLOYER SIGNATURE  GROUP CONTINUATION  QUALIFYING EVENT  STATE OF OHIO – 12 MONTHS  COBRA  1 18 MOS. 29 MOS. 36 MOS.  EFFECTIVE  SIGNATURE DATE   |   |  |                |                 |                               |            |                       |              |                 |  |  |
| □ NEW GROUP □ RECALLED FROM LAYOFF □ QUALIFYING EVENT □ STATE OF OHIO – 12 MONTHS □ OPEN ENROLLMENT □ LOSS OF COVERAGE □ PART-TIME TO FULL-TIME (ATTACH HIPAA CERTIFICATE) □ 18 MOS. □ 29 MOS. □ 36 MOS.  COMPANY NAME X □ SIGNATURE SIGNAT  | CHECK ON  |  |                | EMP             |                               |            | NTINILATIC            | NI.          |                 |  |  |
| □ NEW EMPLOYEE □ OPEN ENROLLMENT □ LOSS OF COVERAGE □ PART-TIME TO FULL-TIME (ATTACH HIPAA CERTIFICATE) □ 18 MOS. □ 29 MOS. □ 36 MOS. □ 18 MOS. □ 29 MOS. □ 36 MOS. □ 18 MOS. □ 29 MOS. □ 36 MOS. □ STATE OF OHIO – 12 MONTHS □ COBRA □ 18 MOS. □ 29 MOS. □ 36 MOS. □ STATE OF OHIO – 12 MONTHS  |   |  | RECALLED FROM  | LAYOFF          |                               |            |                       |              |                 |  |  |
| COMPANY NAME X SIGNATURE DATE SIGNATURE SIGNAT | ☐ OPEN EN   | PLOYEE<br> ROLLMENT 🔲  | LOSS OF COVERA | STATE O         |                               |            | E OF OHIO – 12 MONTHS |              |                 |  |  |
| EMPLOYER SIGNATURE X SIGNATURE DATE  |   |  | •              | •               | □ 18 MOS. □ 29 MOS. □ 36 MOS. |            |                       |              |                 |  |  |
|  | •   |  |                |                 |                               |            |                       |              |                 |  |  |
|  | _   | COVERAGE WILL BE EFFECTIVE IN ACCORDANCE WITH THE ENROLLMENT ELIGIBILITY POLICY ESTABLISHED BETWEEN THE GROUP AND PARAMOUNT.  EFFECTIVE DATE |                |                 |                               |            |                       |              |                 |  |  |