☐ 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 FLEX

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 PREVIOUS NAME ____________________	☐ CHANGE SUBSCRIBER ADDRESS/PHONE	☐ CHANGE SUBSCRIBER PHYSICIAN REASON FOR PCP CHANGE ___________________

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 ☐ M ☐ F	TOBACCO ☐ YES ☐ NO
	- -		

PRIMARY CARE PHYSICIAN NAME	PHYSICIAN ID NUMBER	WILL YOU BE A NEW PATIENT FOR THIS PHYSICIAN? ☐ 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 ___________________

☐ DEPENDENT CHANGE OF PHYSICIAN
REASON FOR PCP CHANGE_______________

DEPENDENTS

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

TOBACCO	RACE & ETHNICITY		PRIMARY CARE PHYSICIAN NAME	ID	NEW PATIENT
❏ YES ❏ NO	❏ W ❏ A ❏ B/AA ❏ AI/AN ❏ NH/PI	❏ HISP/LATINO ❏ NOT HISP/LAT			❏ YES ❏ NO

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

TOBACCO	RACE & ETHNICITY		PRIMARY CARE PHYSICIAN NAME	ID	NEW PATIENT
❏ YES ❏ NO	❏ W ❏ A ❏ B/AA ❏ AI/AN ❏ NH/PI	❏ HISP/LATINO ❏ NOT HISP/LAT			❏ YES ❏ NO

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

TOBACCO	RACE & ETHNICITY		PRIMARY CARE PHYSICIAN NAME	ID	NEW PATIENT
❏ 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

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		PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN ID	NEW PATIENT
❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI	❑ HISP/LATINO ❑ NOT HISP/LAT			❑ YES ❑ NO

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

TOBACCO	RACE & ETHNICITY		PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN ID	NEW PATIENT
❑ YES ❑ NO	❑ W ❑ A ❑ B/AA ❑ AI/AN ❑ NH/PI	❑ HISP/LATINO ❑ NOT HISP/LAT			❑ YES ❑ NO

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: 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 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 CORRECT.

SUBSCRIBER SIGNATURE **X** _____ DATE _____

SPOUSE SIGNATURE **X** _____ DATE _____

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** _____

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

GROUP CONTINUATION
QUALIFYING EVENT _____
❑ STATE OF OHIO – 12 MONTHS
❑ COBRA
❑ 18 MOS. ❑ 29 MOS. ❑ 36 MOS.
EFFECTIVE _____
SIGNATURE DATE _____
EFFECTIVE DATE _____