OMB No. 0938-1378 Expires: 6/30/2026

PARAMOUNT
ELITE | MEDICARE PLANS

PARAMOUNT ELITE
INDIVIDUAL ENROLLMENT REQUEST FORM

AVAILABLE PLANS

HMO-POS Plans

INDIANA

NORTHEAST INDIANA

Paramount Elite Standard (HMO-POS) H3653-015
Service area: *Adams, Allen, DeKalb, Noble.*

SOUTHEAST INDIANA

Paramount Elite Essential (HMO-POS) H3653-024
Service area: *Dearborn, Franklin, Ohio, Switzerland.*

KENTUCKY

Paramount Elite Essential (HMO-POS) H3653-024
Service area: *Boone, Campbell, Kenton.*

MICHIGAN

Paramount Elite Standard (HMO-POS) H3653-015
Paramount Elite Prime (HMO-POS) H3653-022
Paramount Elite Enhanced (HMO-POS) H3653-004
Service area: *Branch, Hillsdale, Lenawee, Monroe, Washtenaw.*

OHIO

GREATER TOLEDO

Paramount Elite Standard (HMO-POS) H3653-015
Paramount Elite Prime (HMO-POS) H3653-022
Paramount Elite Enhanced (HMO-POS) H3653-004
Service area: *Allen, Crawford, Defiance, Erie, Fulton, Hardin, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood, Wyandot.*

GREATER CLEVELAND

Paramount Elite Standard (HMO-POS) H3653-015
Service area: *Ashland, Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Summit, Wayne.*

GREATER CINCINNATI/DAYTON

Paramount Elite Essential (HMO-POS) H3653-024
Service area: *Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Greene, Hamilton, Highland, Madison, Miami, Montgomery, Preble, Shelby, Warren.*

PPO PLAN

Paramount Elite Preferred (PPO) H5232-001
Service area: *Available in all counties above.*

WHO CAN USE THIS FORM?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

WHEN DO I USE THIS FORM?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit medicare.gov to learn more about when you can sign up for a plan.

WHAT DO I NEED TO COMPLETE THIS FORM?

- Your Medicare number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

REMINDERS

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

WHAT HAPPENS NEXT?

Send your completed and signed form to:

Mail: Paramount Elite
P.O. Box 928, Toledo, OH 43697-0928

Fax: 419-291-9984

Email: PHCMBREnrollment@medmutual.com

Once they process your request to join, they'll contact you.

Continued on next page

HOW DO I GET HELP WITH THIS FORM?

Call Paramount Elite at 833-554-2335. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 877-486-2048.

En español: Llame a Paramount Elite al 833-554-2335 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

INDIVIDUALS EXPERIENCING HOMELESSNESS

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

PAPERWORK REDUCTION ACT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Important: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed or forwarded to the plan. See "What happens next?" on the previous page to send your completed form to the plan.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency [FEMA]) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Paramount Elite at 833-554-2335 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday through Friday, 8 a.m. to 8 p.m. From Oct. 1 to March 31, you may call 8 a.m. to 8 p.m., seven days a week.

Continued on next page

SECTION 1 – ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join (reference page 1 for service area):

☐ Paramount Elite Standard (HMO-POS) H3653-015 **$0 per month**
☐ Paramount Elite Prime (HMO-POS) H3653-022 **$27 per month**
☐ Paramount Elite Enhanced (HMO-POS) H3653-004 **$68 per month**
☐ Paramount Elite Essential (HMO-POS) H3653-024 **$0 per month**
☐ Paramount Elite Preferred (PPO) H5232-001 **$0 per month**

First Name: Last Name: Middle Initial (optional):

Birth Date (MM/DD/YYYY): (__ __ / __ __ / __ __ __ __)

Sex: ☐ M ☐ F

Phone Number: (_____)_____

Permanent Residence Street Address:
(Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.)

City: County: State: ZIP Code:

Mailing Address if different from your permanent address (P.O. Box allowed):

Street Address: City: State: ZIP Code:

YOUR MEDICARE INFORMATION

Medicare Number: _ _ _ _ - _ _ _ _ - _ _ _ _

Is entitled to: Hospital (Part A) Effective Date _____
Medical (Part B) _____

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Paramount Elite? ☐ Yes ☐ No
Name of other coverage: _____
Member number for this coverage: _____ Group number for this coverage: _____

IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Paramount Elite.
- By joining this Medicare Advantage Plan, I acknowledge that Paramount Elite will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that when my Paramount Elite coverage begins, I must get all of my medical and prescription drug benefits from Paramount Elite. Benefits and services provided by Paramount Elite and contained in my Paramount Elite "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Paramount Elite will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

  1) This person is authorized under State law to complete this enrollment, and

  2) Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's Date:** _____

If you are the **authorized representative**, sign above and fill out these fields:

Name: _____ Address: _____

Phone Number: (__ __ __) __ __ __ - __ __ __ __ Relationship to Enrollee: _____

Continued on next page

SECTION 2 – ALL FIELDS IN THIS SECTION ARE OPTIONAL

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin?
Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Chinese
- ☐ Filipino
- ☐ Native Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ Other Asian
- ☐ White
- ☐ Samoan
- ☐ Vietnamese
- ☐ Aisian Indian
- ☐ **I choose not to answer**

What's your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

☐ I would like Paramount to send me online communication about health education, news, events, and health reminders apply.

Email: _____

By providing your email you are agreeing to receive emails from us.
We will give you the opportunity to opt-out of all future communications.

Do you work? ☐ Yes ☐ No
Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic or health center: _____

Provider number: _____

Please select Yes if you want us to send you information in a language other than English.

☐ Yes Paramount will contact you relative to this request.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print
☐ Audio CD ☐ Data CD

Please contact Paramount Elite at 833-554-2335 if you need information in an accessible format other than what's listed at left. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. From Oct. 1 to March 31, you may call 8 a.m. to 8 p.m., seven days a week. TTY users can call 711.

PAYING YOUR PLAN PREMIUMS

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB)). DON'T pay Paramount Elite the Part D-IRMAA.

Please select a premium payment option:

☐ **Direct Bill**

☐ **Auto deduction from Social Security or Railroad Retirement Board (RRB) benefit check** (Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. During the period between enrollment and when deductions can be withdrawn, we will send you a paper bill for your monthly premiums. If Social Security or RRB does not approve your request for automatic deduction, we will continue to send you a paper bill for your monthly premiums.) The effective date for premium withholding will not be retroactive. You are responsible for paying the organization directly for all premiums due from enrollment effective date until the month in which premium withholding begins.

I receive monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board (RRB)

☐ **Electronic Funds Transfer (EFT) from your bank account.** Enclose a voided check or the following information:

Account Type: ☐ Checking ☐ Savings

ABA Routing Number |__ __ __ __ __ __ __ __ __| Bank Account Number |__ __ __ __ __ __ __ __ __ __ __ __|

Account Holder's Name _____

Account Holder's Signature _____

COMPLETED APPLICATIONS

Send completed applications to Paramount Elite. **Email**: PHCMBREnrollment@medmutual.com **Fax**: 419-291-9984

Continued on next page

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

OFFICE USE ONLY

Date Enrollment Request Form Received:_____

Effective Date of Coverage (Mo/Day/Year): (__ __ / __ __ / __ __ __ __)

Election Period: AEP: _____ **IEP-E (First IEP for Part D):** _____ **IEP-F:** _____
ICEP: _____ **OEP:** _____ **OEPNEW:** _____
OEPI: _____ (Recently moved into/out of LTC facility)

SEP Election Type (Check eligible election type): Duals and Individuals with LIS (SEP U)

- ☐ Eligible for Medicare and Medicaid
- ☐ Newly eligible for payment help (LIS) with Medicare Rx coverage
- ☐ Recently lost eligibility for LIS (dual-eligible and non-dual-eligible)
- ☐ **Employer Group Health Plan (SEP W)** Recently lost (involuntary) or leaving employer group creditable coverage or enrolling in employer-sponsored coverage.
- ☐ **Change in Residence (SEP V)** Recently moved (permanent) from service area.
- ☐ **Other SEP (SEP S):** Other (describe): _____
  _____
- ☐ **Not Eligible** – Reason: _____
  _____

LIS Copay: ☐ $0 ☐ $1.60/$4.80 ☐ $4.90/$12.15

Initial payment received with application?
☐ No (Member informed that initial bill may be for more than one month's premium)
☐ Yes (Record payment information on the right)

Check #: _____
Date of Check: _____
Amount of Check: _____

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY

Complete this section if you're an individual (e.g., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to Enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only): _____