OMB No. 0938-1378
Expires: 12/31/2026

Individual Enrollment Request Form
to Enroll in a Paramount Elite Plan

HMO-POS and PPO Plans Available

Northwest Ohio
Fulton, Lucas, Ottawa, Sandusky and Wood counties

Southeast Michigan
Branch, Hillsdale, Lenawee, Monroe and Washtenaw counties

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PARAMOUNT
ELITE | MEDICARE PLANS

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 Oct. 15–Dec. 7 each year (for coverage starting Jan. 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 (Oct. 15–Dec. 7), the plan must get your completed form by Dec. 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: 1-440-878-7058

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

How do I get help with this form?

Call Paramount Elite at 1-833-554-2335. TTY users can call 711.

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

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.

En español: Llame a Paramount Elite al 1-833-554-2335 (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.

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Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from Oct. 15 through Dec. 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this 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 this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the Annual Enrollment Period (AEP) from Oct. 15 to Dec. 7.
- ☐ 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) from Jan. 1 to March 31.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to 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 _____/_____/_____.
- ☐ 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 Medicare and get full Medicaid. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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 coverage). I lost my drug coverage on (insert date) _____/_____/_____.
- ☐ I am leaving employer or union coverage on (insert date) _____/_____/_____.
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ 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'm joining a plan with a 5-Star Special Enrollment Period.

If none of these statements applies to you or you're not sure, please contact Paramount Elite at 1-833-554-2335 (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.

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Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join. All plans include prescription drug coverage.

- ☐ **Paramount Elite Standard HMO-POS** (H3653-015-000) – $0 per month
- ☐ **Paramount Elite Prime HMO-POS** (H3653-022-000) – $35 per month
- ☐ **Paramount Elite Enhanced HMO-POS** (H3653-004-000) – $74 per month
- ☐ **Paramount Elite Preferred PPO** (H5232-001-000) – $0 per month

First Name	Last Name	Middle Initial

Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Optional: Email Address*

Home Phone Number ( ) –	Cell Phone Number** ( ) –

Permanent Residence Street Address (Don't enter a PO Box)

City	State	ZIP Code	County

Mailing Address, if different from your permanent address (PO Box allowed)

Street Address

City	State	ZIP Code

Your Medicare Information

Medicare Number __ __ __ __–__ __ __–__ __ __ __	

Answer These Important Questions

☐ **Yes** ☐ **No** Will you have other prescription drug coverage (like VA, TRICARE) in addition to Paramount Elite?

Name of Other Coverage	Member Number for this Coverage	Group Number for this Coverage

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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 or Medicare Prescription Drug Plan, I acknowledge that Paramount 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 on page 7). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can only be enrolled in one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 will pay for benefits or services that are not covered.
- 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 my signature (or the signature of the person legally authorized to act on my behalf) on this application means I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  – This person is authorized under State law to complete this enrollment, and
  – Documentation of this authority is available upon request by Medicare.

Signature	**Today's Date**

If you're the authorized representative, sign above and fill out these fields:

Name	Address
Phone Number ( ) –	
Relationship to Enrollee	

*Email Address: By providing your email address, you are giving express written consent to Medical Mutual and its partners to send plan, care and benefit information to this email address. You can unsubscribe at any time to remove your email address.

**Cell Phone Number: You are providing your express written consent to receive SMS text messages from Medical Mutual and its partners and agreeing to Terms and Conditions at MedMutual.com/About-Medical-Mutual/Legal-Terms-of-Use#texting. You can opt out at any time by replying "STOP" to any text message.

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Section 2 – All fields on this page are optional

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

Fill in a language if you want us to send you information in a language other than English.

☐ _____

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 1-833-554-2335 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.

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

List your Primary Care Physician (PCP), Clinic or Health Center

Physician Name	Physician Phone Number ( ) –	Physician NPI Number
Physician Address		
City	State	ZIP Code

Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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 the Part D-IRMAA.

Please select a premium payment option (If you don't select a payment option, you will get a bill each month):

☐ **Get a bill**

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**

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

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ **Electronic Funds Transfer (EFT) from your bank account each month**

Please enclose a voided check or provide the following information:

Account Type

☐ Checking Account

☐ Savings Account

Bank Routing Number _____

Bank Account Number _____

Account Holder's Name _____

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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 and 1860D-1 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.

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 this page to send your completed form to the plan.

Paramount Elite plans are HMO-POS and PPO plans offered by Paramount with a Medicare contract. Enrollment in a Paramount Elite Advantage plan depends on contract renewal.