

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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ID # _____					
<input type="checkbox"/> CHANGE NAME PREVIOUS NAME _____		<input type="checkbox"/> CHANGE SUBSCRIBER ADDRESS/PHONE _____		<input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	TOBACCO <input type="checkbox"/> YES <input type="checkbox"/> NO	
PRIMARY CARE PHYSICIAN NAME		PHYSICIAN ID NUMBER	WILL YOU BE A NEW PATIENT FOR THIS PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
GROUP NUMBER: 031030	EFFECTIVE DATE	PREFERRED SPOKEN LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> SIGN <input type="checkbox"/> OTHER: _____			
DIVISION NUMBER: 0001					
RACE (MARK ALL THAT APPLY): <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN/ PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN/ALASKAN NATIVE			ETHNIC BACKGROUND: <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC/LATINO		
<input type="checkbox"/> ADD DEPENDENT IF ADDING SPOUSE, MARRIAGE DATE _____		<input type="checkbox"/> DEPENDENT CHANGE OF PHYSICIAN REASON FOR PCP CHANGE _____			

DEPENDENTS

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT			- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER
SOCIAL SECURITY NO. _____					
TOBACCO	RACE & ETHNICITY		NAME	PRIMARY CARE PHYSICIAN ID	NEW PATIENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> B/AA <input type="checkbox"/> AI/AN <input type="checkbox"/> NH/PI	<input type="checkbox"/> HISP/LATINO <input type="checkbox"/> NOT HISP/LAT			<input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT			- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER
SOCIAL SECURITY NO. _____					
TOBACCO	RACE & ETHNICITY		NAME	PRIMARY CARE PHYSICIAN ID	NEW PATIENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> B/AA <input type="checkbox"/> AI/AN <input type="checkbox"/> NH/PI	<input type="checkbox"/> HISP/LATINO <input type="checkbox"/> NOT HISP/LAT			<input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT			- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER
SOCIAL SECURITY NO. _____					
TOBACCO	RACE & ETHNICITY		NAME	PRIMARY CARE PHYSICIAN ID	NEW PATIENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> B/AA <input type="checkbox"/> AI/AN <input type="checkbox"/> NH/PI	<input type="checkbox"/> HISP/LATINO <input type="checkbox"/> NOT HISP/LAT			<input type="checkbox"/> YES <input type="checkbox"/> 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			- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER
SOCIAL SECURITY NO. _____					

TOBACCO	RACE & ETHNICITY	PRIMARY CARE PHYSICIAN	NEW PATIENT
		NAME ID	
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> B/AA <input type="checkbox"/> AI/AN <input type="checkbox"/> NH/PI	<input type="checkbox"/> HISP/LATINO <input type="checkbox"/> NOT HISP/LAT	<input type="checkbox"/> YES <input type="checkbox"/> NO

LAST NAME	FIRST	MIDDLE	BIRTH DATE	SEX	RELATIONSHIP
DEPENDENT			- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER
SOCIAL SECURITY NO. _____					

TOBACCO	RACE & ETHNICITY	PRIMARY CARE PHYSICIAN	NEW PATIENT
		NAME ID	
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> B/AA <input type="checkbox"/> AI/AN <input type="checkbox"/> NH/PI	<input type="checkbox"/> HISP/LATINO <input type="checkbox"/> NOT HISP/LAT	<input type="checkbox"/> YES <input type="checkbox"/> 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 DISABLED OVER AGE 65 END STAGE RENAL DISEASE

MEDICARE PART A EFFECTIVE DATE: _____
 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 <input type="checkbox"/> NEW GROUP <input type="checkbox"/> RECALLED FROM LAYOFF <input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> LOSS OF COVERAGE <input type="checkbox"/> PART-TIME TO FULL-TIME (ATTACH HIPAA CERTIFICATE)	GROUP CONTINUATION QUALIFYING EVENT _____ <input type="checkbox"/> STATE OF OHIO - 12 MONTHS <input type="checkbox"/> COBRA <input type="checkbox"/> 18 MOS. <input type="checkbox"/> 29 MOS. <input type="checkbox"/> 36 MOS.
COMPANY NAME X WASHINGTON LOCAL SCHOOLS	EFFECTIVE _____
EMPLOYER SIGNATURE X _____	SIGNATURE DATE _____
COVERAGE WILL BE EFFECTIVE IN ACCORDANCE WITH THE ENROLLMENT ELIGIBILITY POLICY ESTABLISHED BETWEEN THE GROUP AND PARAMOUNT.	EFFECTIVE DATE _____