THE WABASH MEMORIAL HOSPITAL ASSOCIATION

1501 NORTH WATER STREET - P.O. BOX 1340 - DECATUR, ILLINOIS 62525

Claims Toll Free (888) 800-9161
Claims: (217) 429-5246
Claims Fax: (217) 429-1222

Clinic Toll Free (888)) 419-6435
Clinic: (217) 425-9642
Clinic Fax: (217) 425-9660

Application for Primary Coverage- Early Retiree 60/30 Company Plan

Please Check box that pertains to you:	**Plan**	**Member Monthly Premium**
___ Standard 80/20 Plan w/ $1,000 drug benefit	Bluebird	$ -0-
___ Upgrade Plan with unlimited drugs	Banner Blue	$ 230

Full Name of Applicant_____ _____ _____
(First) (M.I.) (Last)

Social Security No._____ Birth Date _____/_____/_____

Permanent Address:_____
(street)

_____
(city) (state) (zip code)

Home Phone No. (_____)_____ Cell Phone No. (_____)_____

Mailing Address (if different from permanent address)

_____
(street address) (city) (state) (zip code)

Last Date of Employment_____

Name of the railroad from which you retired if other than Wabash_____

Current Employer _____

Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance or VA benefits? (If this insurance is to be discontinued when Wabash coverage becomes effective, you should mark "No" below.)

Yes_____ No_____
If yes, what kind of insurance do you have?_____
Full name of insurance company: _____
Full address of insurance company: _____
Phone No.(____)_____Policy Number:_____

Please enclose a copy of your insurance card with your application

I wish my membership to become effective the first day of _____

_____
(Signature of Applicant) (Date)