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 Coverage –Dependents of Employee NOT Medicare Eligible

Please Check category that pertains to you:
Relationship to Employee Member:
______Spouse/Former Spouse/Widow(er)
______Dependent
______Parent/Parent in-law

Name of Employee Member Applicant is Associated to: ______________________

Type Of Coverage Requested	**Plan #**	**Monthly Premium**
Primary		
___ 80/20 Coverage with no drug benefit	Redbird	$550
___ 80/20 Coverage with $1,000 drug benefit	Redbird PLUS	$600
Secondary (Primary from Railroad)		
__ Spouse or 1 Dependent	Piggyback	$175
__ 2-3 Dependents	Piggyback	$210
__ 4 or More Dependents	Piggyback	$275

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)

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

Please provide information on additional Dependents for which coverage is requested

1. Name: __________________________ Date of Birth _____/______/_______

   Relation to Member _______________ Social Security Number_______________

2. Name: ______________ Date of Birth __/___/_____ Relation to Member __________

   Relation to Member _______________ Social Security Number_______________

3. Name: ______________ Date of Birth __/___/_____ Relation to Member __________

   Relation to Member _______________ Social Security Number_______________

4. Name: ______________ Date of Birth __/___/_____ Relation to Member __________

   Relation to Member _______________ Social Security Number_______________

____

(Signature of Applicant) (Date)