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 _____
2. Name: _____ Date of Birth __/___/_____ Relation to Member _____
3. Name: _____ Date of Birth __/___/_____ Relation to Member _____
4. Name: _____ Date of Birth __/___/_____ Relation to Member _____

(Signature of Applicant) (Date)