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

2018- Application for Primary Coverage Former Employee Not Eligible for Medicare

Please Check box that pertains to you	**Plan #**	**Monthly Premium**
___ 80/20 Coverage with no drug benefit	Redbird	$575
___ 80/20 Coverage with $1,000 drug benefit	Redbird PLUS	$625

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)

Date of Railroad Hire__________ Last Date of Railroad Employment_________

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 card with your application

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

____
(Signature of Applicant) (Date)