

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 - Former Employee Not Eligible for Medicare

<u>Please Check box that pertains to you</u>	<u>Plan #</u>	<u>Monthly Premium</u>
<input type="checkbox"/> 80/20 Coverage with no drug benefit	Redbird	\$550
<input type="checkbox"/> 80/20 Coverage with \$1,000 drug benefit	Redbird PLUS	\$600

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)