

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: _____

<u>Type Of Coverage Requested</u>	<u>Plan #</u>	<u>Monthly Premium</u>
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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)