

# 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

## 2019 - Application for Coverage – Piggyback Plans

**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:** \_\_\_\_\_

<b><u>Type Of Coverage Requested</u></b>	<b><u>Plan #</u></b>	<b><u>Monthly Premium</u></b>
Secondary (Primary from Railroad)		
___ Spouse or 1 Dependent	Piggyback	\$200
___ 2 Dependents	Piggyback	\$250
___ 3 Dependents	Piggyback	\$300
___ 4 or more Dependents	Piggyback	\$400

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 \_\_\_\_\_

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(Signature of Applicant)

(Date)