

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

Redbird & Redbird Plus Plans

Please Check category that pertains to you:

_____ Retired Railroader with Less than 30 Years of Service/Not Medicare Eligible

_____ Spouse/Former Spouse/Widow(er) of Railroader

_____ Dependent of Railroader

_____ Parent/Parent in-law of Railroader

Name of Railroader Applicant is Associated with: _____

Type Of Coverage Requested

Plan

Monthly Premium

Primary

___ 80/20 Coverage with no drug benefit

Redbird

\$575 per person

___ 80/20 Coverage with \$1,000 drug benefit

Redbird PLUS

\$625 per person

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 _____

(Signature of Applicant)

(Date)