

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

2020 - Application for Primary Coverage- Early Retiree 60/30 Company Plan

<u>Please Check box that pertains to you:</u>	<u>Plan</u>	<u>Member Monthly Premium</u>
<input type="checkbox"/> Standard 80/20 Plan w/ \$1,000 drug benefit	Bluebird	\$ -0-
<input type="checkbox"/> Upgrade Plan with unlimited drugs	Banner Blue	\$ 250

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)

Last Date of Employment _____

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 if you have other insurance.

(Signature of Applicant)

(Date)