

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 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: _____

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

(Signature of Applicant)

(Date)