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
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)