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

2021 - Application for Primary Coverage- Early Retiree 60/30 Company Plan

Please Check box that pertains to you:	**Plan**	**Member Monthly Premium**
____Standard 80/20 Plan w/ $1,000 drug benefit	Bluebird	$ -0-
____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)