

# 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 Coverage –Wheeling Lake Erie – Redbird Plus Plan

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 \_\_\_\_\_

Effective date of insurance \_\_\_\_\_

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)