THE WABASH MEMORIAL HOSPITAL ASSOCIATION

P.O. BOX 1340 - DECATUR, ILLINOIS 62525

Claims Toll Free (888) 800-9161
Claims (217) 429-5246
Claims Fax (217) 429-1222

Membership Toll Free (888) 800-9161
Membership (217) 429-5246
Membership Fax (217) 420-4030

2022 - Application for Primary Coverage- Early Retiree 60/30 Company Plan

Mark the plan you are applying for:	**Plan**	**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. (_______)____________________

Date of Retirement____________________

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, please mark "No" below.) If you have other insurance, please enclose a copy of your card.

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 include a copy of your BA6 from the Railroad Retirement Board. You must have at least 360 months of credited service to be eligible. You will not be enrolled in coverage if the BA6 is not provided, or the BA6 does not show the required months of credited service .

____
(Signature of Applicant)