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 Coverage – Piggyback Plans (Secondary Coverage)

Please mark the category that pertains to you:

Relationship to Employee Member:

_____Spouse/Former Spouse/Widow(er)
_____Dependent
_____Parent/Parent in-law

Name of railroader applicant is associated with: _____

Type Of Coverage Requested	**Plan #**	**Monthly Premium**
___ 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. (_____)_____

(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, 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 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)