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

Application for Membership – Active Contract Employee (Primary coverage for Medical/pharmacy benefits)

Through this application, I direct and authorize Norfolk Southern Corporation (NSC) to make monthly payments to **Wabash Memorial Hospital Association** at the amount negotiated and calculated for health and pharmacy benefits for Hospital Association Employees. I understand that my dental, vision, AD&D and primary health coverage for any dependents will continue to be provided by NSC through the National Health and Welfare Plan.

Coverage will commence on the first day of the month for which **Wabash** receives payment from NSC.

PLEASE PRINT THE FOLLOWING INFORMATION

Full Name: ________________________________ Male: ______ Female: ________

Address: ____Apt #:_________

City: __________________________State: _________ Zip: ________________

Home Phone: ( ) ______-__________ Cell Phone No. ( ) ______ - __________

e-mail address ____

SSN __________- _________- ___________

Birth date: ________/________/________ Date employed: ____/____/_____

Location: ___________________________ Occupation: _________________

EID #: __________________________

Union Affiliation: ____

Please Return Completed Application In The Enclosed Envelope
Wabash Memorial Hospital Association - PO Box 1340 - Decatur, IL 62525-1340