

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

2018 - Application for Membership

<u>PLAN</u>	<u>Monthly Premium</u>
Supplemental Plan to Medicare Parts A & B	\$160

PLEASE STATUS THAT PERTAINS TO YOU

Retired Employee Retired Spouse of Employee
 Retired Parent / Parent-in-law of Employee

COMPLETE THE FOLLOWING INFORMATION:

First Name _____ Middle Initial _____ Last Name _____

Social Security No. _____ Birth Date ____/____/____ Sex M F

Home Address: _____

City _____ State _____ Zip _____

Home Phone No. (____) _____ Cell Phone No. (____) _____

Name of Railroad from which you retired if other than the Wabash/ NSC _____

If you are the spouse, parent or parent-in-law of a Wabash Member, please give the member's name: _____

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 card with your application

By joining this plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. I hereby authorize the Social Security Administration and /or the Railroad Retirement Board to furnish information to the Wabash Memorial Hospital Association affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for supplementary medical insurance benefits (Part B) under the title VVIII of the Social Security Act. I also hereby authorize the Social Security Administration to furnish the Plan information as to Part B benefits received, including those based on services not furnished by or through the Plan and should my enrollment under Part B be terminated, the effective month of such termination, for its use in connection with the operation of this Plan.

I wish my Medicare Supplement to become effective ____/____/_____
Medicare # _____

PLEASE FURNISH COPY OF MEDICARE CARD SHOWING PARTS A and B or your letter from the Railroad Retirement Board or Social Security Administration I understand that my signature on this application means that I have read and understand the contents of this application.

Applicant's
Signature _____ Date _____

Wabash Memorial Hospital Association does not exclude or limit membership based on your health condition

***Please mail application back to: WMHA, P.O. Box 1340, Decatur, IL 62525
If you have any questions, please contact Membership Services at #217-429-5246 or toll free at #888-800-9161.***