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

Automatic Withdrawal Authorization Form

I authorize Wabash Memorial Hospital Association (WMHA) to withdraw payment from my bank account for payment of monthly dues on the first of the month for which payment is due.

Name of Member (print clearly): _____

Name of Financial Institution: _____

Date of First Withdrawal: _____/5th/_____

Type of Account
Checking Account ☐
Savings Account ☐
Routing Number_____
Account Number_____

Current Monthly Dues Amount $_____
Note: Member will be notified of any change in dues amount prior to a change in the amount withdrawn from their account.
Frequency of Withdrawal
Monthly ☐
Quarterly ☐

This Automatic Withdrawal Authorization shall remain in effect until WMHA receives written notification from the member of its termination prior to the due date.

Member Signature:_____ Date_____
Phone # we can reach you:_____