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

2017 - Application for Membership

PLAN	**Monthly Premium**
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:____________________________

<u>Please enclose a copy of your card with your application</u>

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.