

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

2019 - 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. () _____ - _____

Email 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***