# 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

## *2020 - 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***