THE WABASH MEMORIAL HOSPITAL ASSOCIATION

P.O. BOX 1340 - DECATUR, ILLINOIS 62525

Claims Toll Free (888) 800-9161
Claims (217) 429-5246
Claims Fax (217) 429-1222

Membership Toll Free (888) 800-9161
Membership (217) 429-5246
Membership Fax (217) 420-4030

2022 - Enrollment Form – Active Contract Employee
(Primary coverage for Medical/Pharmacy benefits)

Through this form, I direct and authorize Norfolk Southern Corporation (NSC) to make monthly payments to **Wabash Memorial Hospital Association** at the amount negotiated and calculated for medical 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: _____

Signature of Applicant: _____ Date: _____

Please return completed form to Wabash Memorial Hospital Association - PO Box 1340 - Decatur, IL 62525. Form may also be faxed to 217-420-4030.