Payment Transmittal Form

Group Name: *Western Area School Health Benefit Plan*

School Name: _____

Premium for the month of _____ year _____

Total amount billed $_____

Check # _____ Check Amount $ _____

Check # _____ Check Amount $ _____

Check # _____ Check Amount $ _____

Check # _____ Check Amount $ _____

Total amount of checks mailed $_____

Date mailed to MidAmerica National Bank:_____

Mail this completed form and payment to:	*Send a photocopy of this form and checks to:*
MidAmerica National Bank PO Box 1300 130 North Side Square Macomb, IL 61455 **MAKE CHECK(S) PAYABLE TO: WESTERN AREA PLAN**	Eligibility Department Consociate PO Box 1068 Decatur, IL 62525-1068 Fax Number: (217) 422-9224 David Thompson 120 West Carroll Street Macomb, IL 61455

Prepared by:	**Phone Number:**	**Date:**
_____	_____	_____