Vision Service Plan
Membership Enrollment Form

Name of Group: University of Massachusetts Medical School	**Group #** 30016233	**Hire Date:**	**Effective Date:** _____ **Coverage Level Elected: (please check one)** ☐ Individual ☐ Family
UMass Employee ID #:	**Member Last Name:**	**Member First Name:**	**Date of Birth (m/d/y)**

Home Address:

PLEASE LIST ALL OF YOUR DEPENDENTS (If Family Coverage is Selected)

LAST NAME	FIRST NAME	DATE OF BIRTH
Spouse		
Children (include surname if different)		

Signature:	Date: