

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) <input type="checkbox"/> Individual <input type="checkbox"/> 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:		
PLEASE RETURN TO YOUR HR/BENEFITS DEPARTMENT. DO NOT RETURN TO VSP.				