Patient Member ID #

your SSN

Relationship to Subscriber

Self ☐ Dependent ☐

Doctor or Store Name where you received service†

Subscriber Last Name†

Subscriber First Name†

MI

Birth Date (MM/DD/YYYY)

Street Address

City

State

Zip Code

Vision Plan Name

UAW/UMass Health & Welfare Trust Fund

Date of Service† (MM/DD/YYYY)

Vision Plan Group #

9794348 for Grads / 9878760 for Postdocs

Subscriber Member ID #

your SSN

†Required

continued