HealthSourceRI
FOR EMPLOYERS

PHONE: 1-855-683-6757
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HSRI_BETeam@connextions.com

Employee Confirmation Record

Employee Information				
Employer Name:			Coverage Effective Date:	
Employee Name:				
DOB:	Sex: ☐ Male ☐ Female			
Home Address:	Street/PO/Apt#:			
	City:		State:	Zip:
Mailing Address: *If Different*	Street/PO/Apt#:			
	City:		State:	Zip:
Date of Hire:	Coverage Start Date:		SSN:	
Primary Tel:			☐ Work ☐ Cell ☐ Home	
Secondary Tel:			☐ Work ☐ Cell ☐ Home	
Email:			☐ Home ☐ Office	
Preferred method of contact: ☐ Tel ☐ Email ☐ Postal Mail				
Preferred time of contact: ☐ Morning ☐ Afternoon ☐ Evening				
Preferred language: ☐ English ☐ Other:				
Requested coverage level and cost to employee:				
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider				

Requested Coverage	Medical	Employee Cost	Dental	Employee Cost
Employee Only				
Employee + Spouse				
Employee + Dependent(s)				
Family				
Waiving Coverage				

Medical Selection	Carrier:
	Plan Name:
Dental Selection	Carrier:
	Plan Name:

Continued — See Page 2

Spouse

First Name:	Middle Initial:	Last Name:	
DOB:	Sex: ☐ M ☐ F	SSN:	
Street/PO/Apt#:			
City:		State:	Zip:
Primary telephone if different from employee:		Primary Language:	
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider			

Dependent

First Name:	Middle Initial:	Last Name:	
DOB:	Sex: ☐ M ☐ F	SSN:	
Street/PO/Apt#:			
City:		State:	Zip:
Primary telephone if different from employee:		Primary Language:	
Relationship to Employee: ☐ Son ☐ Daughter ☐ Other/Provide:			
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider			

Dependent

First Name:	Middle Initial:	Last Name:	
DOB:	Sex: ☐ M ☐ F	SSN:	
Street/PO/Apt#:			
City:		State:	Zip:
Primary telephone if different from employee:		Primary Language:	
Relationship to Employee: ☐ Son ☐ Daughter ☐ Other/Provide:			
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider			

For Employer Use Only

Contribution Group Number: ☐ 1 ☐ 2 ☐ 3 ☐ COBRA

Employee Signature Box

☐ Yes, I have read and agree to the HSRI USER ACCEPTANCE AGREEMENT and know it explains how my personal information will remain private and secure

☐ I agree to my CONSENT FOR ACCESS TO DATA (Rights and Responsibilities)

☐ Confirmation record above reflects my medical and dental plan selections

Employee Name:

Employee Signature: Date:

To add additional dependents, fill out page three and check this box: ☐

Attach to Employee Confirmation Record for:

Dependent

First Name:	Middle Initial:	Last Name:
DOB:	Sex: ☐ M ☐ F	SSN:
Street/PO/Apt#:		
City:	State:	Zip:
Primary telephone if different from employee:	Primary Language:	
Relationship to Employee: ☐ Son ☐ Daughter ☐ Other/Provide:		
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider		

Dependent

First Name:	Middle Initial:	Last Name:
DOB:	Sex: ☐ M ☐ F	SSN:
Street/PO/Apt#:		
City:	State:	Zip:
Primary telephone if different from employee:	Primary Language:	
Relationship to Employee: ☐ Son ☐ Daughter ☐ Other/Provide:		
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider		

Dependent

First Name:	Middle Initial:	Last Name:
DOB:	Sex: ☐ M ☐ F	SSN:
Street/PO/Apt#:		
City:	State:	Zip:
Primary telephone if different from employee:	Primary Language:	
Relationship to Employee: ☐ Son ☐ Daughter ☐ Other/Provide:		
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider		

Dependent

First Name:	Middle Initial:	Last Name:
DOB:	Sex: ☐ M ☐ F	SSN:
Street/PO/Apt#:		
City:	State:	Zip:
Primary telephone if different from employee:	Primary Language:	
Relationship to Employee: ☐ Son ☐ Daughter ☐ Other/Provide:		
Medical coverage? ☐ Dental coverage? ☐ Name of Primary Care Provider		