HealthSourceRI
FOR EMPLOYERS

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# Employer Confirmation Record

| Employer Information | | | | |
|---|---|---|---|---|
| Company Legal Name: | | | | |
| Company Name (DBA): | | | | |
| EIN: | Number of Eligible Employees: | | | |
| Company Address: | Street: | | Suite: | |
| | City: | | State: | Zip: |
| Principal/Owner Name: | | Title: | | |
| Primary Tel: | | ☐ Work ☐ Cell ☐ Home | | |
| Secondary Tel: | | ☐ Work ☐ Cell ☐ Home | | |
| Email: | | | | |
| Primary Contact: | | Title: | | |
| Primary Tel: | | ☐ Work ☐ Cell ☐ Home | | |
| Secondary Tel: | | ☐ Work ☐ Cell ☐ Home | | |
| Email: | | | | |
| Allow an administrator to manage account? Y ☐ N ☐ | | If yes, name: | | Title: |
| Admin Email: | | Admin Tel: | | |
| Choice Model: ☐ Single Plan ☐ Full Employee Choice | | | | |
| Medical Reference Plan: (carrier) | | Specific Plan Name: | | |
| HRA / HSA / FSA (circle one) | | Vendor Name: | | |
| Details: | | | | |
| Metal Level for Customization Only - Optional: ☐ Platinum ☐ Gold ☐ Silver ☐ Bronze | | | | |
| Dental Reference Plan: (carrier) | | Specific Plan Name: | | |
| Employee Groups: ☐ One Only ☐ Multiple | | If multiple, same contribution for all? | | |

**Continued — See Page 2**

| MEDICAL and DENTAL Contributions: Please indicate contribution in a percentage or dollar amount. (as presented for Employees for Open Enrollment) | | |
|---|---|---|
| Group 1 | Employer Medical Contribution | Employer Dental Contribution |
| Employee Only | | |
| Employee + Spouse | | |
| Employee + Dependent(s) | | |
| Family | | |
| Dependents Only (Available for Dental Coverage Only) | | |
| Group 2 | | |
| Employee Only | | |
| Employee + Spouse | | |
| Employee + Dependent(s) | | |
| Family | | |
| Dependents Only (Available for Dental Coverage Only) | | |

| | | |
|---|---|---|
| Effective date: | | Annual Renewal Month: |
| Open enrollment dates: (start) | | (end) |
| Documentation Provided: | Quarterly Tax & Wage: | |
| | Other: | |
| Employer's BROKER OF RECORD: | | |
| Form Completed By: | | Date: |

Please attach a sheet of paper for additional information if needed.

## Employer 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)
- ☐ I authorize Broker named as my Broker of Record

Employer Name:

Employer Signature: Date: