HealthSourceRI
FOR EMPLOYERS

PHONE: 1-855-683-6757

Employer Confirmation Record

Employer Information				
Company Legal Name:				
Company Name (DBA):				
EIN:		Number of Eligible Employees:		
Company Location:	Street:		Suite:	
	City:		State:	Zip:
Company Billing Address:	Street:		Suite:	
	City:		State:	Zip:
Owner Name:		Title:		
Primary Tel:		Work ☐	Cell ☐	Home ☐
Secondary Tel:		Work ☐	Cell ☐	Home ☐
Email:				
Administrator/Primary Contact:		Title:		
Primary Tel:		Work ☐	Cell ☐	Home ☐
Secondary Tel:		Work ☐	Cell ☐	Home ☐
Email:				
Contribution Model: ☐ Composite ☐ List Bill	Choice Model: ☐ Single Plan ☐ Full Employee Choice	Effective Date:		
Medical Reference Plan (carrier):		Specific Plan Name:		
Metal Level for Customization only (optional):	☐ Platinum	☐ Gold	☐ Silver	☐ Bronze
Dental Reference Plan (carrier):		Specific Plan Name:		
Documentation Provided:	Quarterly Tax & Wage:			
	Other:			
Employer's BROKER OF RECORD:				

Continued — See Page 2

Medical and Dental Employer Contributions: Please indicate contribution in percentage or dollar amount (as presented for Employee Open Enrollment). Please note that if choosing List Bill Contribution Model, you can only choose percentage. Dollar amount is not allowed on this model.

Composite Model			List Bill Model		
Group 1	Employer Medical Contribution	Employer Dental Contribution	Group 1	Employer Medical Contribution	Employer Dental Contribution
Employee Only			Employees		
Employee & Spouse			Dependents		
Employee & Dependent(s)			N/A		
Family			N/A		
Dependents Only (available for Dental Coverage only)	N/A		Dependents Only (available for Dental Coverage only)		
Group 2	Employer Medical Contribution	Employer Dental Contribution	Group 2	Employer Medical Contribution	Employer Dental Contribution
Employee Only			Employees		
Employee & Spouse			Dependents		
Employee & Dependent(s)			N/A		
Family			N/A		
Dependents Only (available for Dental Coverage only)	N/A		Dependents Only (available for Dental Coverage only)		
Group 3	Employer Medical Contribution	Employer Dental Contribution	Group 3	Employer Medical Contribution	Employer Dental Contribution
Employee Only			Employees		
Employee & Spouse			Dependents		
Employee & Dependent(s)			N/A		
Family			N/A		
Dependents Only (available for Dental Coverage only)	N/A		Dependents Only (available for Dental Coverage only)		

Employer Signature Box

☐ Yes, I have read and agree to the HealthSource RI for Employers 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: