



## **Employee Confirmation Record**

Employee Informati	on									
Employer Name:				Coverage Start Date:						
First Name:			Middle Na	ame:		ı	Last Na	me:		
Sex: Male	Fem	nale	ate of Birth (mr	n/dd/yy	ууу):		9	SSN:		
Home Address:		D/Apt#:	Apt#:							
Tiome Address.	City:			State:			Zip:			
Mailing Address:	Street/PO/Apt#:									
If Different	City:				State:				Zip:	
Date of Hire: Qualifying Event:										
Primary Tel:					Work Cell			Cell	Home	
Secondary Tel:	Secondary Tel:					Work Cell Home				
Email:										
Medical		D	ental							
Name of Primary (	Care Prov	ider (fo	r Neighborhood	d Plans	s):					
Address of Primar	y Care Pr	ovider	:							
Employer Contribution Group: Group 1				Group 2 Grou			Group 3	3		
Please check (✓)	the appr	opriate	box:							
Requested Covera	ge	Medi	cal ( ✓ )	Emplo	oyee Cost		Dental	( < )	Employee Cost	
Employee Only										
Employee + Spouse										
Employee + Child(ren)										
Family										
Waiving Coverage										
Medical Selection	Carrier:									
	Plan Name:									
Dental Selection	Dental Selection Carrier:									
	Plan Na	ame:								

## **Employee Confirmation Record Continued**

	First Name:	Middle N	lame:		Last Name:				
	Date of Birth (mm/dd/yyyy):	Sex:	М	F	SSN:				
Spouse	Street/PO/Apt#:								
Spo	City:	State:		Zip:		Medical	Dental		
	Name of Primary Care Provider (for Neighb	orhood P	Plans):						
	Primary Care Provider Address:								
	First Name:	Middle N	lame:		Last Name:				
Ħ	Date of Birth (mm/dd/yyyy):	Sex:	М	F	SSN:				
nder	Street/PO/Apt#:								
Dependent	City:	State:		Zip:		Medical	Dental		
	Name of Primary Care Provider (for Neighb	orhood F	Plans):						
	Primary Care Provider Address:								
	First Name:	Middle N	lame:		Last Name:				
ŧ	Date of Birth (mm/dd/yyyy):	Sex:	М	F	SSN:				
Dependent	Street/PO/Apt#:								
ebe	City:	State:		Zip:		Medical	Dental		
	Name of Primary Care Provider (for Neighborhood Plans):								
	Primary Care Provider Address:								
	First Name:	Middle N	lame:		Last Name:				
ent	Date of Birth (mm/dd/yyyy):	Sex:	М	F	SSN:				
	Street/PO/Apt#:								
Depend	City:	State:		Zip:		Medical	Dental		
	Name of Primary Care Provider (for Neighborhood Plans):								
	Primary Care Provider Address:								

## **Employee Signature Box**

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

## **Employee Confirmation Record Continued**

Attach to Employee Confirmation Record for:

	First Name:	Middle Na	ame:		Last Name:		
Ħ	Date of Birth (mm/dd/yyyy):		М	F	SSN:		
nder	Street/PO/Apt#:						
Dependent	City:	State:		Zip:	Medical Dental		
	Name of Primary Care Provider (for Neighb	orhood Pl	lans):				
	Primary Care Provider Address:						
	First Name:	Middle Na	ame:		Last Name:		
Ħ	Date of Birth (mm/dd/yyyy):	Sex:	М	F	SSN:		
nder	Street/PO/Apt#:						
Dependent	City:	State:		Zip:	Medical Dental		
	Name of Primary Care Provider (for Neighborhood Plans):						
	Primary Care Provider Address:						
	First Name:	Middle Na	ame:		Last Name:		
ŧ	Date of Birth (mm/dd/yyyy):	Sex:	М	F	SSN:		
ndent			М	F			
ependent	Date of Birth (mm/dd/yyyy):		M	F Zip:			
Dependent	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:	Sex:			SSN:		
Dependent	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:  City:	Sex:			SSN:		
Dependent	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:  City:  Name of Primary Care Provider (for Neighbor)	Sex:	lans):		SSN:		
	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:  City:  Name of Primary Care Provider (for Neighborn Primary Care Provider Address:	Sex: State:	lans):		SSN:  Medical Dental		
	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:  City:  Name of Primary Care Provider (for Neighborn Primary Care Provider Address:  First Name:	Sex: State: porhood Pl	lans):	Zip:	SSN:  Medical Dental  Last Name:		
	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:  City:  Name of Primary Care Provider (for Neighborn Primary Care Provider Address:  First Name:  Date of Birth (mm/dd/yyyy):	Sex: State: porhood Pl	lans):	Zip:	SSN:  Medical Dental  Last Name:		
Dependent Dependent	Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:  City:  Name of Primary Care Provider (for Neighborn Primary Care Provider Address:  First Name:  Date of Birth (mm/dd/yyyy):  Street/PO/Apt#:	Sex: State:  Middle Na Sex: State:	ans): ame: M	Zip:	SSN:  Medical Dental  Last Name:  SSN:		