HealthSourceRI
FOR EMPLOYERS

Phone: 1-855-683-6757

Employee Confirmation Record

Employee Information			
Employer Name:		**Coverage Start Date:**	
First Name:	**Middle Name:**	**Last Name:**	
Sex: ☐ Male ☐ Female	**Date of Birth (mm/dd/yyyy):**	**SSN:**	
Home Address:	**Street/PO/Apt#:**		
	City:	**State:**	**Zip:**
Mailing Address: If Different	**Street/PO/Apt#:**		
	City:	**State:**	**Zip:**
Date of Hire:	**Qualifying Event:**		
Primary Tel:	☐ Work ☐ Cell ☐ Home		
Secondary Tel:	☐ Work ☐ Cell ☐ Home		
Email:			
☐ Medical ☐ Dental			
Name of Primary Care Provider (for Neighborhood and BlueCHiP Select RI Plans):			
Address of Primary Care Provider:			
Employer Contribution Group: ☐ Group 1 ☐ Group 2 ☐ Group 3			
Please check (✓) the appropriate box:			

Requested Coverage	Medical (✓)	Employee Cost	Dental (✓)	Employee Cost
Employee Only	☐		☐	
Employee + Spouse	☐		☐	
Employee + Child(ren)	☐		☐	
Family	☐		☐	
Waiving Coverage	☐		☐	

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

Continued — See Page 2 ☞

Revised August 25, 2023

Employee Confirmation Record *Continued*

Spouse	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI 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:

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			

Dependent	First Name:	Middle Name:	Last Name:	
	Date of Birth (mm/dd/yyyy):	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	State:	Zip:	☐ Medical ☐ Dental
	Name of Primary Care Provider **(for Neighborhood and BlueCHiP Select RI Plans):**			
	Primary Care Provider Address:			