HealthSourceRI
FOR EMPLOYERS

Phone: 1-855-683-6757

Employee Confirmation Record

Employee Information			
Employer Name:		Coverage Effective Date:	
Employee Name:			
Sex: ☐ Male ☐ Female		Date of Birth (mm/dd/yyyy):	
Home Address:	Street/PO/Apt#:		
	City:	State:	Zip:
Mailing Address: If Different	Street/PO/Apt#:		
	City:	State:	Zip:
Date of Hire:		SSN:	
Primary Tel:		☐ Work ☐ Cell ☐ Home	
Secondary Tel:		☐ Work ☐ Cell ☐ Home	
Email:		☐ Home ☐ Office	
Preferred method of contact: ☐ (Tel) ☐ (Email) ☐ Postal Mail			
Preferred language: ☐ English ☐ Other:			
Medical Coverage? ☐ Dental Coverage? ☐ Name of Primary Care Provider:			
Address 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:
	SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):
	Street/PO/Apt#:		
	City: Primary telephone:	State:	Zip:
	Name of Primary Care Provider:	Medical: ☐	Dental: ☐
	Primary Care Provider Address:		
Dependent	First Name:	Middle Initial:	Last Name:
	SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):
	Street/PO/Apt#:		
	City: Primary telephone:	State:	Zip:
	Name of Primary Care Provider:	Medical: ☐	Dental: ☐
	Primary Care Provider Address:		
Dependent	First Name:	Middle Initial:	Last Name:
	SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):
	Street/PO/Apt#:		
	City: Primary telephone:	State:	Zip:
	Name of Primary Care Provider:	Medical: ☐	Dental: ☐
	Primary Care Provider Address:		
Dependent	First Name:	Middle Initial:	Last Name:
	SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):
	Street/PO/Apt#:		
	City: Primary telephone:	State:	Zip:
	Name of Primary Care Provider:	Medical: ☐	Dental: ☐
	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:

Attach to Employee Confirmation Record for:

Dependent				
First Name:	Middle Initial:	Last Name:		
SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):		
Street/PO/Apt#:				
City: Primary telephone:			State:	Zip:
Name of Primary Care Provider:		Medical: ☐	Dental: ☐	
Primary Care Provider Address:				

Dependent				
First Name:	Middle Initial:	Last Name:		
SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):		
Street/PO/Apt#:				
City: Primary telephone:			State:	Zip:
Name of Primary Care Provider:		Medical: ☐	Dental: ☐	
Primary Care Provider Address:				

Dependent				
First Name:	Middle Initial:	Last Name:		
SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):		
Street/PO/Apt#:				
City: Primary telephone:			State:	Zip:
Name of Primary Care Provider:		Medical: ☐	Dental: ☐	
Primary Care Provider Address:				

Dependent				
First Name:	Middle Initial:	Last Name:		
SSN:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):		
Street/PO/Apt#:				
City: Primary telephone:			State:	Zip:
Name of Primary Care Provider:		Medical: ☐	Dental: ☐	
Primary Care Provider Address:				