HealthSourceRI
FOR EMPLOYERS

Phone: 1-855-683-6757

Employee Confirmation Record

Employee Information				
Employer Name:			**Effective Date:**	
First Name:	**Middle Initial:**		**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:	☐ Home ☐ Office			
Preferred language: ☐ English ☐ Other:				
Medical Coverage? ☐ **Dental Coverage?** ☐ **Name of Primary Care Provider:**				
Address of Primary Care Provider:				
Employer Contribution Group: ☐ Group 1 ☐ Group 2 ☐ Group 3				

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:	
	DOB:	Sex: ☐ M ☐ F	SSN:	
	Street/PO/Apt#:			
	City:	Primary telephone:	State:	Zip:
	Name of Primary Care Provider:	PCP 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:	Primary Language:		
	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:	Primary Language:		
	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:	Primary Language:		
	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:			Primary Language:	
	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:			Primary Language:	
	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:			Primary Language:	
	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:			Primary Language:	
	Primary Care Provider Address:				