Phone: 1-855-683-6757



Employee Confirmation Record

Employee Informati	on									
Employer Name:					Effective Date:					
First Name: Middle Initial:					Last Name:					
Sex: Male Female Date of Birth (mm/do					yyyy): SSN:					
Home Address:	Street/P	treet/PO/Apt#:								
Home Address.	City:					State	:	Zip:		
Mailing Address:	Street/P	O/Apt	#:							
If Different	City:				State:			Zip:		
Date of Hire:		Qual	fying Event:							
Primary Tel:						Work	(Cell	Home	
Secondary Tel:						Work		Cell	Home	
Email:						Home	е	Office		
Preferred languag	e: En	glish	Other:							
Medical Coverage	? De	ntal C	overage?	Name o	of Primary	Care	Provide	er:		
Address of Primar	y Care P	rovid	er:							
Employer Contribu	ution Gro	oup:	Group 1	Group 1 Grou			o 2 Grou		р 3	
Requested Coverage	ge	Me	edical	Emplo	oyee Cost		Dental		Employee Cost	
Employee Only										
Employee + Spouse										
Employee + Dependent(s)										
Family										
Waiving Coverage										
Medical Selection Carrier:										
Medical Selection	Carrier	:								
Medical Selection	Carrier Plan N									
Medical Selection Dental Selection		ame:								

Employee Confirmation Record Continued

	First Name:			e Initial	:	Last Name:				
Spouse	DOB:	Sex:	M	F	SSN:					
	Street/PO/Apt#:									
	City:			State:	Zip:					
	Name of Primary Care Provi	PCP Address:								
	First Name:				:	Last Name:				
Ħ	SSN:			М	F	Date of Birth (mm/dd/yyyy):				
Dependent	Street/PO/Apt#:									
ebe	City:	Primary	telepho	ne:			State:	Zip:		
Ω	Name of Primary Care Provi	ider:	Primary Language:							
	Primary Care Provider Address:									
Ħ	First Name:	Middle	e Initial	:	Last Name:					
	SSN:	Sex:	М	F	Date of Birth (mm/dd/yyyy):					
Dependent	Street/PO/Apt#:									
ebei	City:	telephor	ne:			State:	Zip:			
	Name of Primary Care Provi	Primary Language:								
	Primary Care Provider Addre	ess:								
	First Name:			e Initial	:	Last Name:				
¥	SSN:			М	F	Date of Birth (mm/dd/yyyy):				
Dependent	Street/PO/Apt#:									
ebe	City:	/ telepho	ne:			State:	Zip:			
	Name of Primary Care Provi	Primary Language:								
	Primary Care Provider Addre	ess:								

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 Initial:			Last Name:			
¥	SSN:			M	F	Date of Birth	(mm/dd/yyyy):		
nden	Street/PO/Apt#:								
Dependent	City:		State:	Zip:					
	Name of Primary Care Provi	Primary Language:							
	Primary Care Provider Addre	ess:	_						
	First Name:			Initial:		Last Name:			
¥	SSN:		Sex:	М	F	Date of Birth	(mm/dd/yyyy):		
nden	Street/PO/Apt#:								
Dependent	City:	Primary te	elephone):			State:	Zip:	
	Name of Primary Care Provid	der:				Primary Lang	_anguage:		
	Primary Care Provider Addre	ess:							
	First Name:					Last Name:			
	First Name:		Middle	Initial:	:	Last Name:			
ŧ	First Name:	Sex:	Middle M	Initial: F		Last Name: Birth (mm/dd/	уууу):		
ndent		Sex: N					уууу):		
Dependent	SSN:	Sex: N	M	F			yyyy): State:	Zip:	
Dependent	SSN: Street/PO/Apt#:	Primary t	M	F			State:	Zip:	
Dependent	SSN: Street/PO/Apt#: City:	Primary t	M	F		 Birth (mm/dd/	State:	Zip:	
Dependent	SSN: Street/PO/Apt#: City: Name of Primary Care Provi	Primary t	M	F e:	Date of	 Birth (mm/dd/	State:	Zip:	
	SSN: Street/PO/Apt#: City: Name of Primary Care Provi	Primary t	M telephon	F e:	Date of	Birth (mm/dd/	State:	Zip:	
	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre	Primary t	telephon	F e: Initial:	Date of	Birth (mm/dd/	State: guage:	Zip:	
	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre First Name: SSN:	Primary t	Middle Sex:	F e: Initial:	Date of	Birth (mm/dd/	State: guage:	Zip:	
Dependent Dependent	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre First Name: SSN: Street/PO/Apt#:	Primary to der:	Middle Sex:	F e: Initial:	Date of	Birth (mm/dd/	State: guage: (mm/dd/yyyy): State:		