

Employee Confirmation Record

Employee Informat	ion										
Employer Name:					Coverage Start Date:						
First Name: Middle Initial:					Last Name:						
Sex: Male Female Date of Birth (mm/dd/y					yyy): SSN:						
Home Address:	Street/P	O/Apt	k#:								
nome Address.		State:				Zip:					
Mailing Address:	Street/P	O/Apt	#:								
If Different		State:):		Zip:				
Date of Hire:		Qual	ifying Event:								
Primary Tel:						Worl	٢	Cell	Но	Home	
Secondary Tel:					Work Cell			Но	Home		
Email:					Home Office						
Preferred languag	je: En	glish	Other:								
Medical Coverage	? De	ental C	Coverage?	Name c	of Primary	v Care	Provide	er:			
Address of Prima	ry Care P	Provid	er:								
Employer Contrib	ution Gro	oup:	Group 1		Group 2 Gro			Group	շսթ 3		
Requested Covera	ge	Me	edical	Emplo	oyee Cost		Dental		E	mployee Cost	
Employee Only											
Employee + Spous											
Employee + Dependent(s)											
Family											
Waiving Coverage											
Medical Selection	Carrie	r:									
	Plan Name:										
Dental Selection Carrier:											
	Plan N	ame:									

Employee Confirmation Record Continued

Dependent	First Name:	Middle Initial	:	Last Name:					
	DOB:	Sex: M	F	SSN:					
	Street/PO/Apt#:								
	City:	Primary te	ephone:			State:	Zip:		
	Name of Primary Care Provi	der:				1			
	Primary Care Provider Address:								
	First Name:	Middle Initial	:	Last Name:					
	Date of Birth (mm/dd/yyyy):	Sex: M	F	SSN:					
	Street/PO/Apt#:								
	City:	elephone:			State:	Zip:			
	Name of Primary Care Provider:								
	Primary Care Provider Address:								
	First Name:	Middle Initial	:	Last Name:					
ŧ	Date of Birth (mm/dd/yyyy):	Sex: M	F	SSN:					
Dependent	Street/PO/Apt#:								
eper	City:	elephone:			State:	Zip:			
Δ	Name of Primary Care Provider:								
	Primary Care Provider Address:								
	First Name:	Middle Initial	:	Last Name:	e:				
ŧ	Date of Birth (mm/dd/yyyy):	Sex: M F		SSN:					
dent	Street/PO/Apt#:								
Depende	City:	elephone:			State:	Zip:			
D	Name of Primary Care Provider:								
	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:

Attach to Employee Confirmation Record for:

Dependent	First Name:	Middle Initial: Last Nam							
	SSN:	Sex:	Μ	F	Date of Birth	h (mm/dd/yyyy):			
	Street/PO/Apt#:								
	City:	telephone:				State:	Zip:		
	Name of Primary Care Provider:								
	Primary Care Provider Address:								
	First Name:	Middle Initial: Last Name:							
ŧ	SSN:		Sex:	Μ	F	Date of Birth	(mm/dd/yyyy):		
Dependent	Street/PO/Apt#:								
ebe	City:	Primary te	elephone	:			State:	Zip:	
	Name of Primary Care Provider:								
	Primary Care Provider Address:								
	First Name:		Middle	Initial:		Last Name:			
ıt	First Name: SSN:	Sex: N	Middle A	Initial: F		Last Name: 3irth (mm/dd/	уууу):		
ndent		Sex: N					уууу):		
)ependent	SSN:	Sex: N Primary t	Л	F			yyyy): State:	Zip:	
Dependent	SSN: Street/PO/Apt#:	Primary t	Л	F				Zip:	
Dependent	SSN: Street/PO/Apt#: City:	Primary t der:	Л	F				Zip:	
Dependent	SSN: Street/PO/Apt#: City: Name of Primary Care Provi	Primary t der:	Л	F e:	Date of B			Zip:	
	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre	Primary t der:	elephone	F e: Initial:	Date of I	Birth (mm/dd/		Zip:	
	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre First Name:	Primary t der:	elephone Middle	F e: Initial:	Date of I	Birth (mm/dd/	State:	Zip:	
	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre First Name: SSN:	Primary t der:	M elephone Middle Sex:	F e: Initial: M	Date of I	Birth (mm/dd/	State:	Zip:	
Dependent Dependent	SSN: Street/PO/Apt#: City: Name of Primary Care Provi Primary Care Provider Addre First Name: SSN: Street/PO/Apt#:	Primary t der: ess: Primary	M elephone Middle Sex:	F e: Initial: M	Date of I	Birth (mm/dd/	State: (mm/dd/yyyy):		