HealthSourceRI
FOR EMPLOYERS

Phone: 1-855-683-6757

Employee Confirmation Record

Employee Information			
Employer Name:		**Coverage Start 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 ☞

Employee Confirmation Record *Continued*

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:				
	Primary Care Provider Address:				

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

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

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