HealthSourceRI
FOR EMPLOYERS

PHONE: 1-855-683-6757

Employer Confirmation Record

Employer Information				
Company Legal Name:				
Company Name (DBA):				
EIN:		Number of Eligible Employees:		
Company Location:	Street:		Suite:	
	City:		State:	Zip:
Company Billing Address:	Street:		Suite:	
	City:		State:	Zip:
Owner Name:		Title:		
Primary Tel:		Work	Cell	Home
Secondary Tel:		Work	Cell	Home
Email:				
Administrator/Primary Contact:		Title:		
Primary Tel:		Work	Cell	Home
Secondary Tel:		Work	Cell	Home
Email:				
Contribution Model: List Bill Composite	Choice Model: Single Plan Full Employee Choice	Effective Date:		
Medical Reference Plan: (carrier)		Specific Plan Name:		
Metal Level for Customization only (optional):	Platinum	Gold	Silver	Bronze
Dental Reference Plan: (carrier)		Specific Plan Name:		
Documentation Provided:	Quarterly Tax & Wage:			
	Other:			
Employer's BROKER OF RECORD:				

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MEDICAL and DENTAL Contributions: Please indicate contribution in a percentage or dollar amount. (as presented for Employees for Open Enrollment)		
Group 1	Employer Medical Contribution	Employer Dental Contribution
Employee Only		
Employee + Spouse		
Employee + Dependent(s)		
Family		
Dependents Only (available for Dental Coverage only)		
Group 2	Employer Medical Contribution	Employer Dental Contribution
Employee Only		
Employee + Spouse		
Employee + Dependent(s)		
Family		
Dependents Only (available for Dental Coverage only)		
Group 3	Employer Medical Contribution	Employer Dental Contribution
Employee Only		
Employee + Spouse		
Employee + Dependent(s)		
Family		
Dependents Only (available for Dental Coverage only)		

Employer Signature Box

- ☐ Yes, I have read and agree to the HealthSource RI for Employers 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)
- ☐ I authorize Broker named as my Broker of Record

Employer Name:

Employer Signature: Date: