J&K Third Party Administrator

Integrated HRA Enrollment Form – City of Cincinnati Employees

EMPLOYER INFORMATION

Employer Name: **City of Cincinnati**

Please send completed enrollment forms and information to:

City of Cincinnati Risk Management - 805 Central Avenue, Suite 100 - Cincinnati, OH 45202
Fax: 513.352.3761 / Email: Phyliss.Ward@Cincinnati-oh.gov
For Questions Call: 877-872-4232 or email CinciHRA@JandKcons.com

PARTICIPANT INFORMATION

Employee Name:		Birthdate:	Hire Date:
Social Security No:	Employee ID No.:	Gender: ☐ M ☐ F	Date Eligible for HRA:
Home Street Address:			
City:		State:	Zip Code:
Home Phone:		Work Phone:	Cell Phone:
Email Address:			

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: ☐ M ☐ F
Social Security No:	Spouse's Employer:	

Spouse's Pay Period for Health Premium Contribution: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Spouse's Health Premium Contribution Pay Period: _____ **** INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT**

Are Spouse's Health Premium Contribution / Deductions: ☐ Before Taxes **(OR)** ☐ After Taxes

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.
If submitting a spousal paystub, please circle the contribution/deduction amount on the submitted paystub.
* DO NOT BLACKOUT THE PAY PERIOD.
** Send a copy of your spouse's paystub that shows the NEW contribution/deduction amount for the effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan.
***** If your spouse's plan has a High Deductible with an HSA, Health Savings Account, you are not eligible to participate in the Integrated HRA, unless the spouse's employer allows your spouse to drop the HSA portion of the plan. **If your primary health insurance coverage is through Medicare, Tricare, or any City of Cincinnati sponsored health plan you are not eligible for the Integrated HRA.**

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize the City of Cincinnati to enroll me into the employer sponsored Integrated HRA. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. I further understand that if any current contributions are made to an HDHP/HSA, I am ***not eligible*** to participate in the Integrated HRA offered through the City of Cincinnati.

Employee Signature: **Date:**