Catilize Health 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@catilizehealth.com

I am enrolling in the Integrated HRA for (Please check one): ☐Single ☐Family

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:		Union Affiliation:	

SPOUSE/EQUAL PARTNER INFORMATION

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

Spouse/Equal Partner's Pay Period for Health Premium Contribution: ☐Monthly ☐Semi-Monthly ☐Bi-Weekly ☐Weekly
Please indicate if the medical deduction DOES NOT come out of each paycheck. Some may be only once a month or the first two pays of the month.

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

Are spouse/equal partner'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/equal partner'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/equal partner's plan. *Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may be only once a month or the first two pays of each month.*
* If your spouse/equal partner'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/Equal Partner's employer allows your spouse/equal partner to drop the HSA portion of the plan. **If your primary health insurance coverage is through Medicare, Tricare (Retiree only), or any City of Cincinnati sponsored health plan you are not eligible for the Integrated HRA.**

*****You must provide proof of dependent eligibility i.e. marriage certificate, birth certificate, etc.*****

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:		

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 a Health Savings Account (HSA), I am *not eligible* to participate in the Integrated HRA offered through the City of Cincinnati.**

Employee Signature: **Date:**

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