Retirees

ATTESTATION OF ENROLLMENT – CITY OF CINCINNATI EMPLOYEES IN A NON-CITY OF CINCINNATI EMPLOYER GROUP HEALTH PLAN

Employee Name: _____ Work Phone: _____

City Employee ID: _____ Email: _____

This form applies to individuals who participate in the Integrated HRA and hereby waive enrollment in the City of Cincinnati Anthem 80/20 medical plan.

To participate in this program, employees, spouses/equal partners, and eligible dependents must provide proof of enrollment in a non-City of Cincinnati group health plan. By signing below, I certify that:

-- The City of Cincinnati has offered me and/or my spouse and/or my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Affordable Care Act of 2010 ("ACA").

-- I and/or my spouse and/or my eligible dependents are enrolled in a group health plan of another employer (such as my spouse's employer) (my Alternate Group Health Plan) that does not consist solely of "excepted benefits" under ACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement"(reimbursement of health care expenses up to a dollar limit).

-- I understand that by enrolling in the HRA, I am waiving participation in the City of Cincinnati group health plan.

For confirmation that my alternate group health plan meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer.

I further certify that my alternate coverage is not:

- High Deductible Health Plan (HDHP) with active contributions to a health savings account (HSA)
- Medicare or Tricare (Retiree only), Medicaid
- Health Insurance Coverage made available thru the Affordable Care Act
- Individual policy
- Limited Benefit Health Plans
- You are NOT eligible if your alternate coverage is through another City of Cincinnati employee

_____ _____

Employee Signature Date

_____ _____

Spouse's Signature ONLY IF ELIGIBLE FOR HRA Date

For more information, please contact Catilize Health at the below contact information.

PLEASE COMPLETE THIS FORM AND SEND TO CATILIZE HEALTH VIA FAX, EMAIL OR MAIL.

CATILIZE HEALTH
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143
Toll Free Phone: 877-872-4232
CinciHRA@catilizehealth.com
Toll Free Fax: 877-599-3724