*Catilize Health Third Party Administrator*
877-872-4232
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# Cincinnati Retirement System - HRA Enrollment Form

## PLAN SPONSOR INFORMATION

**Cincinnati Retirement System**

**Send Completed Form To:** Cincinnati Retirement System, 801 Plum Street, Suite 328, Cincinnati, OH 45202 OR FAX 513-352-1520. For questions contact CRS at 513-352-3227 or retirement@cincinnati-oh.gov

Important Notes:
1.) If the alternate non-City sponsored Group Health Plan is a High Deductible Plan with an HSA (Health Savings Account), you are not eligible to participate in the HRA unless the employer allows the participant to drop the HSA portion of the plan.
2.) If your primary health insurance coverage is through Medicare, Tricare for Retired Military, or any City of Cincinnati sponsored health plan you are not eligible for the HRA.

## PENSIONER INFORMATION

| | | |
|---|---|---|
| Pensioner Name: | Date of Birth: | Gender: ☐M ☐F |
| Social Security No: | HRA Effective Date: | |
| Home Address:<br>(Street, City, State, Zip) | | |
| Home Phone: | Work Phone: | Cell Phone: |
| Email Address: | | |

## SPOUSE INFORMATION

| | | |
|---|---|---|
| Spouse Name: | Date of Birth: | Gender: ☐M ☐F |
| Social Security No: | HRA Effective Date: | |
| Email Address: | Work Phone: | Cell Phone: |

## 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: | | |

## PENSIONER AUTHORIZATION

I understand that by enrolling in this HRA, I am waiving participation in a CRS Health Care Plan. I hereby authorize the Cincinnati Retirement System to enroll me in the CRS sponsored HRA. I agree to comply with the terms and conditions of the plan. I further understand that if any current contributions are made to an HDHP/Health Spending Account (HSA), I am ***not eligible*** to participate in the HRA offered through the Cincinnati Retirement System.

**Pensioner Signature:** **Date:**