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 CRSHealthcare@cincinnati-oh.gov

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

PENSIONER INFORMATION		
Pension Name:	Birthdate:	
Social Security 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 Employer:	

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:		

PENSIONER AUTHORIZATION

* If the other coverage is a HDHP and your spouse is not enrolled in the HSA, your spouse may contribute to the HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the HRA. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by the HRA. Also, if your primary health coverage is through Medicare, Tricare or Medicaid, you are not eligible for the HRA.

I hereby authorize my employer to enroll me into the employer sponsored HRA. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for HRA benefits.

Pensioner Signature: **Date:**