

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

Retiree Name: _____

Work Phone: _____

Work Location: _____

Email: _____

This form applies to individuals who participate in the CRS HRA and who waive coverage in the CRS medical plan.

Retirees, spouses, and eligible dependents who are waiving coverage in the CRS health plan certify that:

-- The CRS 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 alternate coverage (such as my spouse’s employer) that does not consist solely of “excepted benefits” under the 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 CRS HRA, I am waiving participation in the CRS health plan for the following participants:

Name

Name

Name

Name

Attach a separate sheet if space is needed for additional participants

For confirmation that the alternate coverage 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:

- A High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, **it is acceptable alternate coverage** if contributions can be waived. A spouse who is not enrolled in the CRA HRA may contribute to an HSA and use the HSA funds.
- The HSA funds CANNOT be used for medical expenses for members enrolled in the CRS HRA.
- Medicare, Tricare, VA health care or Medicaid
- Health Insurance coverage made available thru the Affordable Care Act
- An individual policy
- A Limited Benefit Health Plan
- Coverage through another City of Cincinnati retiree

Retiree Signature

Date

Spouse’s Signature ONLY IF ELIGIBLE FOR CRS HRA

Date

For more information, please contact Catilize Health® @ 877-872-4232

PLEASE COMPLETE THIS FORM AND SEND TO CINCINNATI RETIREMENT SYSTEM VIA FAX, EMAIL OR MAIL:

**Cincinnati Retirement System
801 Plum Street, Suite 328
Cincinnati, OH 45202
Email: crshealthcare@cincinnati-oh.gov
Fax: 513-352-1520**