



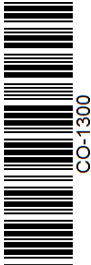
HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

ENROLLMENT FORM  
RETIREE HEALTH FUND

SUBMIT COMPLETED  
FORM TO YOUR AGENCY  
HUMAN RESOURCES/  
PAYROLL OFFICE

CO-1300 (Rev 12/2019)

<b>EMPLOYEE INFORMATION</b>	Last Name	First Name, Middle Initial	Employee Number
	Street Address		Job Record Number
	City, State, Zip Code		Social Security Number
	Is Employee healthcare-eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Agency Dept. ID	Date of Hire
<b>PRIOR SERVICE</b>	<b>List any prior State service during which Employee made Retiree Health Fund Contributions</b>		
	Agency	From	To
Identify Contribution Type and use same one below: <input type="checkbox"/> OPEB <input type="checkbox"/> OPE2 <input type="checkbox"/> OTRS <input type="checkbox"/> OTR2			
Was refund of Retiree Health Fund Contributions issued? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, see CO-1302			
<b>DEDUCTION</b>	<input type="checkbox"/> OPEB - 3% of compensation	<b>Pay Period Start Date</b> (Month/Date/Year)	
	<input type="checkbox"/> OPE2 - 3% of compensation	____ _	
<input type="checkbox"/> OTRS - 1.75% of compensation (Teachers Retirement System Members)	<b>Employer Share:</b> <input type="checkbox"/> OPEB 3% <input type="checkbox"/> OTR 1.75%		
<input type="checkbox"/> OTR2 - 1.75% of compensation	<b>Start Date:</b> ____/____/____		
<b>EMPLOYEE ACKNOWLEDGEMENT: I understand that completion of this form is for the purpose of monitoring my obligation to contribute to the Retiree Health Fund for a total of 10 years or until I retire, whichever comes first.</b>			
Employee Signature		Date	
<b>EXEMPTION</b>	<b>Is Exemption Claimed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, identify reason below</b>		
	<input type="checkbox"/> Exempt employee:	<input type="checkbox"/> Adjunct Faculty	<input type="checkbox"/> Not Healthcare-Eligible
	<input type="checkbox"/> Not eligible for Retirement Plan participation		
	<input type="checkbox"/> Other retiree coverage - Attach signed Affidavit (CO-1303) and Waiver (CO-1304)		
<input type="checkbox"/> Employee has completed Retiree Health Fund			
Authorized Agency Signature		Title	Date
Agency Contact (Print Name)		Agency Contact Telephone	Agency Contact Email



CO-1300

Return to OSC, Employee Benefits Unit, Healthcare Policy & Benefit Services Division,  
165 Capitol Avenue, Hartford, CT 06106.



CO-1300

CO-1300 OPEB ENROLLMENT