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)

EMPLOYEE INFORMATION	Last Name	First Name, Middle Initial	Employee Number
	Street Address		Job Record Number
	City, State, Zip Code		Social Security Number
	Is Employee healthcare-eligible? ☐ Yes ☐ No	Agency Dept. ID	Date of Hire

PRIOR SERVICE	**List any prior State service during which Employee made Retiree Health Fund Contributions**		
	Agency	From	To
	Identify Contribution Type and use same one below: ☐ OPEB ☐ OPE2 ☐ OTRS ☐ OTR2		
	Was refund of Retiree Health Fund Contributions issued? ☐ Yes ☐ No If yes, see CO-1302		

DEDUCTION	☐ OPEB - 3% of compensation ☐ OPE2 - 3% of compensation ☐ OTRS - 1.75% of compensation (Teachers Retirement System Members) ☐ OTR2 - 1.75% of compensation	**Pay Period Start Date** (Month/Date/Year) ___ ___ _____ **Employer Share:** ☐ OPER 3% ☐ OTER 1.75% **Start Date:**____/____/ _____

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.

Employee Signature	Date

EXEMPTION

Is Exemption Claimed? ☐ Yes ☐ No **If yes, identify reason below**

☐ Exempt employee: ☐ Adjunct Faculty ☐ Not Healthcare-Eligible ☐ Not eligible for Retirement Plan participation

☐ Other retiree coverage - Attach signed Affidavit (CO-1303) and Waiver (CO-1304)

☐ Employee has completed Retiree Health Fund contributions

Authorized Agency Signature	Title	Date
Agency Contact (Print Name)	Agency Contact Telephone	Agency Contact Email

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

CO-1300

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