**HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**

**55 Elm Street, Hartford, CT 06106**

**860-702-3480**

**CO-1304 (Rev. 07/15)**

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| **WAIVER OF RETIREE HEALTH PLAN PARTICIPATION** | | | | | http://barcode.tec-it.com/barcode.ashx?code=Code39FullASCII&modulewidth=fit&data=*CO-1304*&dpi=96&imagetype=gif&rotation=0&color=&bgcolor=&fontcolor=&quiet=0&qunit=mm |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby waive my right to participate in the State of Connecticut retiree health benefit program. I understand that my eligibility to waive participation in this program and to be exempt from the obligation to contribute the required percentage of my compensation to the State of Connecticut Retiree Health Fund is contingent upon my providing proof that I am eligible for coverage under another retiree health benefit plan (excluding Medicare, COBRA, or a spousal plan coverage.)  I understand that this waiver cannot be revoked unless the third-party retiree medical coverage, upon which this waiver is based, becomes unavailable to me, other than as a result of my own choice or action. In the event that my third-party retiree health care coverage becomes unavailable, I acknowledge that I will be required to contribute the required percentage of my compensation to the State of Connecticut Retiree Health Care Fund for at least 10 years in order to qualify for State of Connecticut retiree health benefits. | | | | |
| Executed this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_.  By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | | | |  |
| *This Section To Be Completed by Authorized Office of the State Comptroller Personnel* | | | | |
| Employee ID: |  | Employee Last Name: |  | |
| **Return Completed Form to: OSC, Employee Benefits Unit, Healthcare Policy & Benefit Services Division**  **55 Elm Street, Hartford, CT 06016** | | | | | |