



HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

ENROLLMENT FORM
RETIREE HEALTH FUND

SUBMIT COMPLETED
FORM TO YOUR AGENCY
HUMAN RESOURCES/
PAYROLL OFFICE

CO-1300 (Rev 11/2011)

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| EMPLOYEE INFORMATION | Employee Name (last, first, middle initial) | Former Name | Employee Number |
| | Social Security Number | Department ID | Job Record Number |
| | Street Address | Date of Hire | Date of Birth |
| | City, State, Zip Code | Office Telephone No. | Home Telephone No. |
| | Name & Address of Employing Agency | Is Exemption Claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is Employee healthcare-eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| PRIOR SERVICE | List any prior State service during which you made Retiree Health Fund Contributions | | Dates of Service |
| | Agency | From | To |
| | Did you receive a refund of your Retiree Health Fund Contributions? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <p>EMPLOYEE ACKNOWLEDGEMENT: I understand that completion of this form is for the purpose of monitoring my obligation to contribute to the Retiree Health Fund and that such deduction will continue until I have made such contributions for 10 years or until I retire, whichever comes first. I acknowledge that the Deduction Stop Date shown below is only an estimate and that any unpaid leave of absence may extend the period of time during which I am required to make this contribution.</p> | | | |
| Employee Signature | | Date | |
| Deduction Type: | | Deduction Start Date (Month/Date/Year) | |
| <input type="checkbox"/> OPEB | | ___ / ___ / ___ | |
| <input type="checkbox"/> OTRS (Teachers Retirement System Members only) | | Deduction End Date: | |
| | | ___ / ___ / ___ | |
| Basis for exemption (Check One) | | | |
| <input type="checkbox"/> Exempt employment category -- Circle one: Adjunct faculty / Not Healthcare Eligible / Seasonal Employee / Not eligible for Retirement Plan participation | | | |
| <input type="checkbox"/> Other retiree coverage -- Attach signed Affidavit (CO-1303) and Waiver Form (CO-1304) | | | |
| <input type="checkbox"/> Employee has completed Retiree Health Fund contributions | | | |
| AUTHORIZED AGENCY SIGNATURE | | TITLE | DATE |
| AGENCY CONTACT (PRINT NAME) | | AGENCY CONTACT NUMBER | |

MAKE A COPY FOR YOUR RECORDS

If an exemption is claimed, return this form to OSC, Healthcare Policy & Benefit Services Division, 55 Elm Street, Hartford, CT 06106.