



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: <input type="checkbox"/> OPEB <input type="checkbox"/> OTRS (Teachers Retirement System Members only)		Deduction Start Date (Month/Date/Year) ___ / ___ / ___ 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.