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: ___ / ___ / _____

CO-1300

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.