**HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**

*SUBMIT COMPLETED FORM TO YOUR AGENCY HUMAN RESOURCES/ PAYROLL OFFICE*

**APPLICATION FOR REFUND**

**RETIREE HEALTH CONTRIBUTIONS**

**CO-1301 (Rev. 07/15)**

**Part I- Refunds of Retiree Health Fund contributions are available to employees who are completely separating from State service without qualifying for retiree health coverage. Current employees may apply for refund of any Retiree Health Fund contribution collected in error.**

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| --- | --- | --- | --- | --- |
| **EMPLOYEE INFORMATION** | Last Name  | First Name, Middle Initial | Employee Number | http://barcode.tec-it.com/barcode.ashx?code=Code39FullASCII&modulewidth=fit&data=*CO-1301*&dpi=96&imagetype=gif&rotation=0&color=&bgcolor=&fontcolor=&quiet=0&qunit=mm |
| Street Address | Social Security Number |
| City, State, Zip Code | Home Telephone No. | Employee Personal Email |
| Agency Name and Department ID | Date of Termination | Job Record Number |
| **SERVICE** | **EMPLOYEE**—In addition to the agency listed above do you hold any other position(s) with the State of Connecticut— including part-time or adjunct faculty positions with an institution of higher education?□ Yes □ NoIf yes. identify the agency or institution | **AGENCY**– List dates during which Retiree Health Fund Contributions were deducted: List applicable deduction code: □ OPEB □ OPE2 □ OTRS □ OTR2 |
| **AGENCY SECTION** | **REFUND REASON**□ Erroneous Deduction (**check reason):** **\_\_** Not Healthcare-Eligible \_\_ Adjunct faculty\_\_ Wrong Deduction Code \_\_ Wrong Dollar Amount□ Other retiree coverage : Attach signed Affidavit (CO-1303) and Waiver (CO-1304) □ Separation from service with all State of Connecticut agencies and institutions | **REFUND AMOUNT : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Override spreadsheet sent to Central Payroll for payment** **on Check Date: \_\_\_ / \_\_\_ / \_\_\_****Agency did not process refund** □ |
| **EMPLOYEE ACKNOWLEDGMENT: I understand that obtaining a refund upon termination will cause me to lose credit for service needed to qualify for retiree health benefits. If I am rehired, I will have 60-days in which to elect to repay previously refunded amounts and acknowledge that unless I do so, the service listed above will not be counted toward my eligibility for retiree health coverage**.  |
| EMPLOYEE SIGNATURE | DATE |
| **AGENCY CERTIFICATION: I hereby certify that all the information on this application has been verified and is correct**. |
| AUTHORIZED AGENCY SIGNATURE  | TITLE | DATE |
| AGENCY CONTACT (PRINT NAME) | Agency Contact Telephone | Agency Contact E mail  |

**Return to OSC, Employee Benefits Unit. Healthcare Policy & Benefit Services Division**

**55 Elm Street, Hartford, CT 06016**