

Refunds of Retiree Health 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. Former employee refunds will be processed in the payment method on file at separation.

EMPLOYEE INFORMATION	Last Name	First Name, Middle Initial	Employee Number
	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
	Do you hold any other position(s) with the State of Connecticut - including part-time or adjunct faculty positions? <input type="checkbox"/> Yes <input type="checkbox"/> No		

AGENCY SECTION	List dates during which Retiree Health Fund Contributions were deducted: _____	Does employee have a pending disability retirement application? <input type="checkbox"/> Yes <input type="checkbox"/> No
	REFUND REASON <input type="checkbox"/> Erroneous Deduction (check reason) <input type="checkbox"/> Not Healthcare-Eligible <input type="checkbox"/> Adjunct faculty <input type="checkbox"/> Wrong Deduction Code <input type="checkbox"/> Wrong Dollar Amount <input type="checkbox"/> Other retiree coverage: Attach signed Affidavit (CO-1303) and Waiver (CO-1304) <input type="checkbox"/> Separation from service with all State of Connecticut agencies and institutions <input type="checkbox"/> Death	If yes, do not process refund request until final decision. List deduction code to be refunded: _____ REFUND AMOUNT: _____ Override spreadsheet sent to Central Payroll for payment on Check Date: ___ / ___ / ___ Agency did not process refund <input type="checkbox"/>

EMPLOYEE ACKNOWLEDGEMENT: 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
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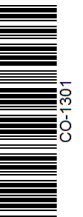
AGENCY CERTIFICATION: I hereby certify that all the information on this application has been verified and is correct.

Authorized Agency Signature	Title	Date
Agency Contact (Print Name)	Agency Contact Telephone	Agency Contact Email

Agencies: Mail completed form to OSC, 165 Capitol Avenue, Hartford, CT 06106



CO-1301



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