



## HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

### APPLICATION FOR REFUND RETIREE HEALTH CONTRIBUTIONS

SUBMIT COMPLETED  
FORM TO YOUR AGENCY  
HUMAN RESOURCES/  
PAYROLL OFFICE

CO-1301 (Rev. 12/2019)

**Part I - 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**

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

Return to OSC, Employee Benefits Unit, Healthcare Policy & Benefit Services Division,  
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Osc.Opeb@ct.gov



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