HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

RETIREE HEALTH FUND PAYMENT ADJUSTMENT

SUBMIT COMPLETED FORM TO YOUR AGENCY HUMAN RESOURCES/ PAYROLL OFFICE

CO-1328 (Rev. 12/2019)

Part I - General Information

This form should be used to authorize additional payments to the Retiree Health Fund due to missed contributions, use of an incorrect deduction code or similar reasons, such as erroneous issuance of a refund. (All adjustments are implemented by using the ADJOPE deduction code. Applicability of employer share (ADJOER) to be determined by OSC).

EMPLOYEE INFORMATION

Last Name	First Name, Middle Initial	Employee Number
Street Address	City, State, Zip Code	Job Record Number
Date of Hire/Rehire	Date of Birth	Office Telephone No.
Employee's Personal Email	Home Telephone No.	Department ID
Name & Address of Employing Agency		

AGENCY SECTION

AMOUNT DUE: $ _____

☐ Lump sum paid on _____

☐ ____ installments of $ _____ per pay period

ADJOPE START DATE ___ / ___ / _____

ADJOPE END DATE ___ / ___ / _____

ADJOER START DATE ___ / ___ / _____

ADJOER END DATE ___ / ___ / _____

Reason for Payment:

☐ Missed Contributions: From: _____ To: _____

☐ Wrong Deduction Code: From: _____ To: _____

Reason for Payment:

☐ Erroneous Refund: From: _____ To: _____

☐ Other: _____

CO-1328

EMPLOYEE ACKNOWLEDGEMENT: I authorize the deduction of the above amount from my paycheck until the amount due to the Retiree Health Fund is paid in full. I understand that this payment is in addition to my regular contribution to the Retiree Health Fund and that the end date shown above will be extended if I miss one or more installments for any reason.

Employee Signature	Date

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

Authorized Agency Signature	Title	Date
Agency Contact (Print Name)	Agency Contact Number	
OSC Signature	Employer Share Due? ☐ Yes ☐ No	

MAKE A COPY FOR YOUR RECORDS
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CO-1328