CO-1329 Rev. 12/2019

HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

APPLICATION FOR REFUND
INCORRECTLY CODED
RETIREE HEALTH FUND CONTRIBUTIONS

SUBMIT COMPLETED FORM TO YOUR AGENCY HUMAN RESOURCES/ PAYROLL OFFICE

Part I - General Information

This form should be used to apply for a refund of incorrectly coded deductions to the Retiree Health Fund. Receipt of a refund will extend the end date for Retiree Health Fund contributions and result in a forfeiture of associated service credit for purposes of retiree healthcare eligibility.

EMPLOYEE INFORMATION

Name (last, first, middle initial)	Former name	Employee Number
Street Address	Department ID	Job Record Number
City, State, Zip Code	Date of Hire	Date of Birth
Employee Personal Email	Office Telephone No.	Home Telephone No.
Name & Address of Employing Agency		

SERVICE CREDIT

AGENCY

a) List date when employee started correct Retiree Health Fund Deduction Code: __ / __ / __

b) List date when employee was first required to contribute to Retiree Health Fund: __ / __ / __

Subtract (b) from (a) to determine forfeited service credit: __ **Year(s)** __ **Month(s)** __ **Day(s)**

AGENCY SECTION

DEDUCTION CODE ERROR
(check one and fill in dates below)

☐ OPE2 instead of OPEB

☐ OTR2 instead of OTRS

Applied from: __ / __ **/ 20**__ **to** __ / __ **/ 20**__

REFUND AMOUNT: $ ______________

ALL REFUNDS MUST BE VERIFIED AND PROCESSED BY THE HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

EMPLOYEE ACKNOWLEDGEMENT: Instead of repaying missed or insufficient contributions from current compensation I request a refund of amounts that I paid to the Retiree Health Fund under an incorrect deduction code. I understand that the end date of my Retiree Health Fund contribution will be 10 years from the date when the correct Retiree Health Fund deduction code started and acknowledge that receipt of a refund will cause me to forfeit credit for the service listed above for purposes of retiree health benefit eligibility.

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 No.	Agency Contact email address

MAKE A COPY FOR YOUR RECORDS
Return to OSC, Healthcare Policy & Benefit Services Division
165 Capitol Avenue, Hartford, CT 06106
E-mail: Osc.opeb@ct.gov