HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

APPLICATION FOR REFUND
RETIREE HEALTH CONTRIBUTIONS

SUBMIT COMPLETED FORM TO YOUR AGENCY HUMAN RESOURCES/ PAYROLL OFFICE

CO-1301 (Rev 5/2018)

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

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?
☐ Yes ☐ No

AGENCY SECTION

List dates during which Retiree Health Fund Contributions were deducted:

_____

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

☐ Death

Does employee have a pending disability retirement application?
☐ Yes ☐ No

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 ☐

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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

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**

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