



**HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**

**ENROLLMENT FORM  
RETIREE HEALTH FUND**

SUBMIT COMPLETED  
FORM TO YOUR AGENCY  
HUMAN RESOURCES/  
PAYROLL OFFICE

**CO-1300 (Rev. 5/2010) To be completed by employee at time of hire, rehire or return from unpaid leave of absence.**

<b>EMPLOYEE INFORMATION</b>	Employee Name (last, first, middle initial)	Former Name	Employee Number
	Social Security Number	Department ID	Job Record Number
	Street Address	Date of Hire	Date of Birth
	City, State, Zip Code	Office Telephone No.	Home Telephone No.
	Name & Address of Employing Agency	Is Exemption Claimed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is Employee healthcare eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO

<b>SERVICE RECORD</b>	AGENCY NAME - List actual service chronologically. Do not include periods of unpaid leaves of absence	DATES OF SERVICE FROM TO		LENGTH OF CREDITED SERVICE YRS. MOS	
	List all unpaid leaves of absence (except Workers Comp.) in chronological order				

**EMPLOYEE ACKNOWLEDGMENT: I understand that completion of this form is for the purpose of monitoring my obligation to contribute 3% of my compensation to the Retiree Health Fund and that such deduction will remain in effect until I have made such contribution for the period set forth in the SEBAC 2009 Agreement. I acknowledge that the deduction stop date shown below is only an estimate and that any unpaid leave of absence may extend the period of time during which I am required to make this contribution.**

EMPLOYEE SIGNATURE	DATE
DEDUCTION START DATE: _____/____/____	DEDUCTION END DATE _____/____/____

**IF AN EXEMPTION IS CLAIMED THIS FORM MUST BE RETURNED TO HEALTHCARE POLICY & BENEFIT SERVICES DIVISION. CHECK BASIS FOR EXEMPTION.**

- Deduction not required (employee has met service requirements)
- Exempt employee - Circle one: Adjunct faculty / Not Healthcare Eligible / Seasonal Employee
- Other retiree coverage - (Attach signed Affidavit (CO-1303) and Waiver (CO-1304) forms)

**FOR EXEMPTIONS BASED ON OTHER RETIREE COVERAGE, RETURN A COPY OF THIS FORM AND SUPPORTING DOCUMENTS TO: OSC, HEALTHCARE POLICY & BENEFIT SERVICES DIVISION, 55 Elm St., Hartford, CT 06106**

AUTHORIZED AGENCY SIGNATURE	TITLE	DATE
AGENCY CONTACT (PRINT NAME)	AGENCY CONTACT NUMBER	

**AGENCY: RETAIN ORIGINAL IN PERSONNEL FILE**