**HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**

**165 Capitol Avenue, Hartford, CT 06106**

**860-702-3480**

**CO-1303 (Rev. 12/2019)**

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| STATE OF |  | | | | http://barcode.tec-it.com/barcode.ashx?code=Code39FullASCII&modulewidth=fit&data=*CO-1303*&dpi=96&imagetype=gif&rotation=0&color=&bgcolor=&fontcolor=&quiet=0&qunit=mm |
| COUNTY OF |  | | | |
| **AFFIDAVIT** | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , being duly sworn, hereby depose and say:   1. I am employed as the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. In that capacity, I am responsible for administering my employer’s benefits program. 2. I am providing this affidavit at the request of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a former employee, in order to enable him or her to waive his or her right to future retiree health benefits from the State of Connecticut and to avoid payment of a mandatory percentage of compensation toward the cost of future retiree health. 3. This will certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has completed \_\_\_\_\_ years of service with the above employer and is, therefore, entitled to coverage under our retiree health insurance plan when he/she attains the age of \_\_\_\_ or otherwise qualifies for commencement of retirement benefits under our plan. 4. I am attaching to this affidavit a true copy of the retiree health insurance, medical plan or other governing document pursuant to which the former employee’s retirement health benefits are provided.   **[Please attach a copy of retiree health insurance/medical plan or governing statute]** | | | | |
| Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sworn to me and subscribed  Before me this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_.  Notary Public: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My Commission Expires \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | [Affix Seal] | |
| *This Section To Be Completed by Authorized Office of the State Comptroller Personnel* | | | | |
| Employee ID: |  | Employee Last Name: | |  |
| **Return Completed Form to: OSC, Employee Benefits Unit, Healthcare Policy & Benefit Services Division**  **165 Capitol Avenue, Hartford, CT 06016** | | | | | |

**Instructions for Completing Affidavit**

Fill in the State and Country where the Affidavit will be signed.

Print your name clearly on the first (unnumbered line of the Affidavit.

In paragraph #1, insert your title in the space provided on the first line. Then insert the name and address of your employer.

In paragraph #2, insert the former employee’s name.

In paragraph #3, insert the former employee’s name, the number of years of service he or she completed, and the age at which the employee will be entitled to retiree coverage.

Attach a true copy of your retiree health plan, as requested in paragraph #4. (If you are a public employer and do not have a written plan document, please attach a copy of the statute or municipal ordinance pursuant to which retiree health coverage is provided.)

Take the Affidavit to a notary public and sign it in his or her presence. Do not sign the Affidavit beforehand. (Most bank branches have a notary public on staff.) Print your name under your signature.

Make sure the Notary Public affixes the notarial seal and indicates the date his or her commission expires.

Return the **original** Affidavit to: The former employee.

If you have any questions concerning the Affidavit, please contact the Office of the State Comptroller, Healthcare Policy & Benefit Service Division, 860-702-3486.