

**EMPLOYEE**

**INFORMATION**

**AGENCY INSTRUCTIONS**



**HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**

**REDUCTION OF RETIREE HEALTH FUND CONTRIBUTION**

**DEADLINE TO ELECT IS 9/14/2017**

*SUBMIT COMPLETED*

*FORM TO YOUR AGENCY*

*HUMAN RESOURCES/*

*PAYROLL OFFICE*

**CO-1330** (8/2017)

**Part I - General Information**

**Employees enrolled in the State Employees Retirement System (SERS) who wish to reduce their Retiree Health Fund Contributions for a one-year period beginning on September 29, 2017 must complete this form and submit it to your agency’s Payroll/Personnel Office no later than September 14, 2017**

Employee Name (last, first, middle initial)

Department ID

Employee Number

Street Address

Office Telephone No.

Job Record Number

City, State, Zip Code

Hire Date

Home Telephone No.

Name & Address of Employing Agency

Employee Personal Email

**The agency is responsible for submitting this deduction change to the OSC Payroll Division using the OVERRIDE SPREADSHEET PROCESS by 09/15/2017.**

**A new deduction code—LOPEB—will be substituted by the Payroll Division for the affected employee’s existing Retiree Health Fund deduction, either OPEB or OPE2.**

**ARP and TRS Members are not eligible for this.**

**EMPLOYEE ACKNOWLEDGEMENT:**

**I elect to reduce my Retiree Health Fund contributions by a total of 1.5% for a one-year period beginning Sept. 29, 2017. By so doing, I agree to repay an additional 0.5% of compensation to the Retiree Health Fund over a four-year period beginning July 1, 2019. Throughout the repayment period my Retiree Health Fund contribution will be 3.5% of my then-current compensation.**

**If I leave state service before paying the amount due for my deferred Retiree Health Fund contributions, I will repay the present value of the remaining amount due in a lump sum and agree that this amount may be withheld from my final paycheck. I acknowledge that if I fail to repay the amount due to the Retiree Health Fund, any retiree health benefits to which I am entitled will be suspended until the total is paid in full.**

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

Date

Agency Contact (Print Name)

Agency Contact Number

**MAKE A COPY FOR YOUR RECORDS**

**Return to OSC, Healthcare Policy & Benefit Services Division**

**55 Elm Street, Hartford, CT 06106**

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