HEALTHCARE POLICY & BENEFIT SERVICES DIVISION

REDUCTION OF RETIREE HEALTH FUND CONTRIBUTION

SUBMIT COMPLETED FORM TO YOUR AGENCY HUMAN RESOURCES/ PAYROLL OFFICE

DEADLINE TO ELECT IS 9/14/2017

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 INFORMATION	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
AGENCY INSTRUCTIONS	**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
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E-mail: Osc.opeb@ct.gov

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