RETIREE HEALTH ENROLLMENT/CHANGE FORM

CO-744-OE REV.10/2026

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
165 Capitol Ave.
Hartford, CT 06106-1775
www.osc.ct.gov

State of Connecticut Retiree Health Plan Medicare Wrap Option Enrollment Statement and Acknowledgment

Type or print and forward to the Retirement Health Insurance Unit.

Enrollment Information

Name of Retiree	**Employee Number** (From Active Employment)	**Street Address** (no P.O. boxes)	
City	**State** / **Zip Code**	**Phone Number**	**Date of Birth** (MM/DD/YYYY)
Name of Dependent, if applicable:	**Dependent Date of Birth** (MM/DD/YYYY)		

Election Acknowledgment

I understand that it is my decision to enroll in the State of Connecticut Retiree Health Plan Medicare Wrap Option and disenroll from the Medicare Advantage Option.

By signing below, I acknowledge that I have been provided with and understand the following:

- The State of Connecticut Retiree Health Plan Medicare Wrap Option and the Medicare Advantage Option offer the same coverage for the benefits provided under the State's retiree health plan.
- The State of Connecticut Retiree Health Plan Medicare Wrap Option is being offered to simply address requests from retirees who prefer to have traditional Medicare with a supplemental plan.
- The State of Connecticut Retiree Health Plan Medicare Wrap Option does not include the additional benefits offered through the Medicare Advantage Option, such as SilverSneakers, non-emergency transportation, provided meals following certain medical treatments, and other Medicare Advantage supplemental benefits.
- There is no monthly premium for the Medicare Advantage Option. The monthly premium for the Medicare Wrap Option is $379.00 per person, per month for the 2027 calendar year.
- I understand that the purpose of choosing the Medicare Wrap Option is to have traditional Medicare with a supplemental plan.
- I understand that by enrolling in the Medicare Wrap Option, I will be disenrolled from the Medicare Advantage Option.
- I have had the opportunity to ask questions regarding the Medicare Wrap Option and understand the election I am making.

I am voluntarily requesting enrollment in the State of Connecticut Retiree Health Plan Medicare Wrap Option, and understand that I will remain enrolled in the Medicare Wrap Option and will be responsible for all applicable monthly premiums for one year, until the next Medicare Open Enrollment Period.

Signature of Retiree	**Date**

Please complete this form and email to osc.rethealth@ct.gov