

**Productivity Enhancement Program for 2017  
Enrollment Form**

Name \_\_\_\_\_ Salary Grade \_\_\_\_\_ SS# xxx-xx-\_\_\_\_\_  
 Health Insurance Plan \_\_\_\_\_  
 Individual [ ] or Family Coverage [ ] (CHECK ONE)  
 Agency Name \_\_\_\_\_

By signing this document, I elect to participate in the 2017 portion of the Productivity Enhancement Program (PEP) and agree to the provisions contained in the [Productivity Enhancement Program Description](#) (hereafter program description) that is available on the BSC Website under Benefits Forms and Publications, Health Insurance, 2017 PEP Information. I understand that I must meet all the eligibility criteria as set forth in the program description in order to participate.

I understand that, in accordance with the program description, I will surrender leave accruals standing to my credit as a result of participation and that ALL of these leave credits will be deducted from my leave balances at the time my enrollment is processed. Furthermore, I understand that no portion of this leave will be returned to me under any circumstances. I wish to apportion this leave forfeiture as follows:

	<b>CSEA-DC-37-PEF-M/C</b>	<b>PEF Institution Teachers</b>
<b>Salary Grade 1-17</b>	Choose 3 or 6 days _____ Hrs vacation leave _____ Hrs personal leave _____	Choose between 1 to 6 days _____ Hrs personal leave _____
<b>Salary Grade 18-24 (to SG 23 for M/C)</b>	Choose 2 or 4 days _____ Hrs vacation leave _____ Hrs personal leave _____	Choose between 1 to 4 days _____ Hrs personal leave _____

In exchange for forfeiting this accrued leave I will receive a credit as set forth in the program description to be applied against the employee share cost of 2017 plan year NYSHIP health insurance. Pursuant to the program description, the amount of this credit will be established at the time of enrollment and will be adjusted only upon movement between individual and family coverage. I will not receive any amount of credit that exceeds the cost of the employee share of my NYSHIP health insurance premiums paid during that period.

I understand that this enrollment form is for the 2017 program year only.

I understand that in order to participate this completed election form must be filed with the Business Services Center by the close of business on **December 2, 2016**. Completed forms can be sent to the BSC Benefits Unit by: Fax (518) 457-1879, or E-mail [BSCBenefitsAdmin@ogs.ny.gov](mailto:BSCBenefitsAdmin@ogs.ny.gov), or mail to BSC Benefits Administration Unit, 1220 Washington Ave, Building #5 Harriman State Campus, Albany, NY 12226-1900.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PERSONAL PRIVACY PROTECTION LAW NOTIFICATION**

This information is being requested pursuant to New York State Civil Service Law section 161-a for the principal purpose of determining eligibility for the Productivity Enhancement Program for 2017. This information will be used in accordance with Public Officers Law section 96(1). Failure to provide this information may result in a denial of eligibility to participate in the Productivity Enhancement Program for 2017. This information will be maintained by the employee's Agency Personnel Office. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

**For Business Services Personnel Only:**

Employee's payroll/employment percentage: \_\_\_\_\_ Salary Grade: \_\_\_\_\_ Total number of days forfeited: \_\_\_\_\_

Hours of leave deducted from employee's balance:

Vacation \_\_\_\_\_ Personal \_\_\_\_\_ Date \_\_\_\_\_

**Verification of eligibility.** I certify that this applicant meets the eligibility criteria necessary for participation in this program.

Name \_\_\_\_\_ Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Health Benefits Administrators Only:**

Date Processed \_\_\_\_\_  
 Biweekly Health Insurance Premium Contribution Credit \_\_\_\_\_  
 Name \_\_\_\_\_ Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_