Productivity Enhancement Program for 2015
Enrollment Form

Name _____ Salary Grade_____ SS#_____
Health Insurance Plan _____
Individual [ ] or Family Coverage [ ] (CHECK ONE)

By signing this document, I elect to participate in the 2015 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 in my agency personnel office. 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:

	CSEA-PEF-M/C	**PEF Institution Teachers**
Salary Grade 1–17	Choose 3 or 6 days _____ Hrs vacation leave_____Hrs personal leave_____	Choose between 1 to 6 days _____ Hrs personal leave_____
Salary Grade 18–24 (to SG 23 for M/C)	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 2015 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 2015 program year only.

I understand that in order to participate this completed election form must be filed with **OGS Business Services Center (BSC)** Benefits Unit by the close of business on **November 28, 2014.** If you have any questions, please contact the BSC at 518-457-4272, Option 2, then Option 3, or e-mail: BSCBenefitsAdmin@ogs.ny.gov. Completed forms can be e-mailed or faxed to 518-457-1879**.**

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 2015. 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 2015. This information will be maintained by the Business Services Center (BSC) Benefits. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

For OGS BSC Benefits Office 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 _____

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