NEW YORK STATE | Office of General Services
Business Services Center

Business Services Center - Human Resources
1220 Washington Ave, Building 5
Albany, NY 12226-1900
Phone: (518) 457-4272 | **Fax:** (518) 457-1879
Email: BSCHRForms@ogs.ny.gov

2024 Productivity Enhancement Program Enrollment Form

APPLICANT INFORMATION

Name	Salary Grade	Last 4 SS#	Email Address	Phone Number

Enrollment	Health Insurance Plan	Agency Name
☐ Individual ☐ Family		

By signing this document, I elect to participate in the 2024 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:

Bargaining Unit & Grade Level	Days/Accruals
CSEA and M/C Salary Grade 1-17	**1. Choose:** ☐ 4 days **-or-** ☐ 8 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
CSEA Salary Grade 18-24	**1. Choose:** ☐ 2.5 days **-or-** ☐ 5 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
M/C Salary Grade 18-23	**1. Choose:** ☐ 2.5 days **-or-** ☐ 5 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
PEF Salary Grade 1-17	**1. Choose:** ☐ 4 days **-or-** ☐ 8 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
PEF Salary Grade 18-24	**1. Choose:** ☐ 2.5 days **-or-** ☐ 5 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
DC-37 Salary Grade 1-17	**1. Choose:** ☐ 3 days **-or-** ☐ 6 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
DC-37 Salary Grade 18-24	**1. Choose:** ☐ 2 days **-or-** ☐ 4 days **2. Specify:** _____ Hours Vacation Leave _____ Hours Personal Leave
PEF Institution Teachers Salary Grade 1-17	**1. Choose between 1 to 8 days:** _____ **2. Specify:** _____ Hours Personal Leave _____ Hours Floating Holiday _____ Hours Compensatory Time
PEF Institution Teachers Salary Grade 18-24	**1. Choose between 1 to 5 days:** _____ **2. Specify:** _____ Hours Personal Leave _____ Hours Floating Holiday _____ Hours Compensatory Time

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 2024 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 2024 program year only.

I understand that in order to participate, this completed election form must be filed with the Business Services Center (BSC) by the close of business on December 11, 2023. Completed forms can be sent to the BSC by: fax (518) 457-1879, or email BSCHRForms@ogs.ny.gov, or mail to the Business Services Center, 1220 Washington Ave, Building 5, Harriman State Campus, Albany, NY 12226-1900.

_____ _____ Clear Form

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 2024. 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 2024. 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 CENTER USE ONLY

Employee's payroll/employment percentage: _____ % **Salary Grade:** _____ **Total number of days forfeited:** _____

Hours of leave deducted from employee's balance: _____ Vacation _____ Personal _____ Date Leave Deducted

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

_____ _____ _____ _____
Name **Signature** **Title** **Date**

For Health Benefits Administrators Only:

Date processed: _____ **Bi-weekly Health Insurance Premium Contribution Credit:** _____

_____ _____ _____ _____
Name **Signature** **Title** **Date**