

SUNY M/C Productivity Enhancement Program for 2014 – Enrollment Form

Name (PRINT) _____ Last four digits of SS# _____

Health Insurance Plan _____

Individual [] or Family Coverage [] (CHECK ONE)

Full Time [] or Part Time [] (CHECK ONE)

Annual Salary of \$59,312 or below: Surrender 3 [] or 6 [] days of Annual leave (CHECK ONE)

Annual Salary of \$59,313 up to \$77,454: Surrender 2 [] or 4 [] days of Annual leave (CHECK ONE)

By signing this document, I elect to participate in the 2014 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 campus Human Resources Office. I understand that I must meet the eligibility criteria explained in the Program Description in order to participate.

I understand that full-time employees earning up to \$59,312 will surrender either 3 or 6 days of Annual leave, and full-time employees earning more than \$59,312 and up to \$77,454 will surrender either 2 or 4 days of Annual leave as a result of participation in the program, and that part-time employees will forfeit Annual leave on a prorated basis in accordance with their payroll/employment percentage in return for a prorated credit. I understand 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.

In exchange for forfeiting this accrued leave I will receive a health insurance contribution credit (hereafter "credit") to be applied against the employee share cost of NYSHIP health insurance premiums paid in the 2014 NYSHIP plan year. The maximum possible amount of this credit for full-time employees is \$500 for 2 or 3 days exchanged and \$1,000 for 4 or 6 days exchanged. The maximum credit for part-time employees will be prorated based upon the employee's payroll/employment percentage. 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 understand that 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 only applies to the 2014 NYSHIP plan year. I understand that in order to participate, this completed election form must be filed with my campus **Human Resources Office (DOTY 318) by the close of business on November 29, 2013.**

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 2014. 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 2014. This information will be maintained by the employee's Agency Personnel Office. For further information relating only to the Personal Privacy Protection Law, contact pio@cs.state.ny.us.

For Agency Human Resources Office Only:

Full-time _____ Part-time _____ (check one)

Days of annual leave deducted from employee's balance: _____ 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 Contribution Credit _____

Name _____ Title _____

Signature _____ Date _____